ROLE OF SOCIAL STIGMA AND CONVENTIONAL BELIEFS IN SHAPING FAMILY PERCEPTION OF INDIVIDUALS WITH PSYCHIATRIC DISORDERS

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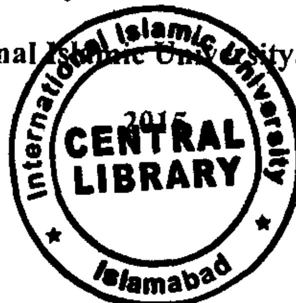
2015



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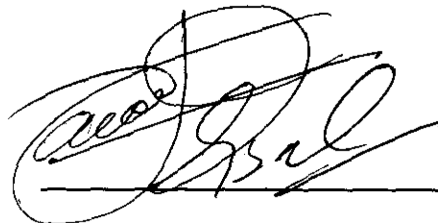

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It is certified that dissertation on a "**ROLE OF SOCIAL STIGMA AND CONVENTIONAL BELIEFS IN SHAPING FAMILY PERCEPTION OF INDIVIDUALS WITH PSYCHIATRIC DISORDERS**", submitted by **INAYAT SHAH** Registration No. 102-FSS-MSPSY/F-12 has been approved for submission in its present form as to satisfy the partial fulfilment of the degree of MS Psychology.

(Dr. Muhammad Tahir Khalily)

Supervisor

"DEDICATED TO MY GREAT & LOVING MOTHER

WHOSE CONSTANT PATIENCE HAS ALWAYS BEEN A ROLE MODEL FOR

ME"

DECLARATION

I hereby declare that the work presented in the following thesis is my own effort except, where otherwise acknowledged and that the thesis is my composition. No part of the thesis has been previously presented for any other degree.

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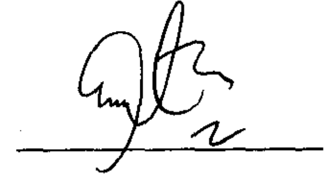

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Abbreviations

LSES	Low Socio Economic Status
MSES	Middle Socio Economic Status
DDS	Discrimination Devaluation Scale
PPS	Perceived Public Stigma subscale
FGDs	Focused Group Discussions
ICB	Intensity of Conventional Beliefs
PMH	Proper Mental Health
PAMHBefore	Preference / Attitudes towards Proper Mental Health before treatment
PAMHAfter	Preference / Attitudes towards Proper Mental Health After treatment
ICBbfMh	Intensity of Conventional Beliefs before seeking Proper Mental Health Services
PATH	Preference/ Attitudes towards Traditional Healing

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Appendix A	Consent Form
Appendix B	Demographic Sheet
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Abstract

The present study aims to explore the presence of conventional beliefs of individuals about mental illness and the social stigma attached to it. Consequently, it also focuses on the impact of social stigma and conventional beliefs of patients' family members in the context of access to psychiatric treatment.Historically, in Pakistani society traditional healing approaches (peeri/faqeeri, jadu/tona) are mostly in practice for Psychiatric Disorders in general. For this purpose family members (guardian and immediate caretaker) of 50 psychiatric patients convenient sample was included in this study. A translated version in Urdu of Perceived Public Stigma subscale of Discrimination Devaluation Scale, semi structured interview were used to collect data. Focused Group Discussion of Experts also helped to highlight social stigma and conventional beliefs associated with mental illness and its impacts on the behavior of people to access public mental health services.

Majority of the care givers age range 20 – 40 years.The study showed a significant negative relationship ($r = -.664$, $p < 0.001$) between intensity of conventional beliefs and attitude towards proper mental health services, and a significant positive relationship ($r = .765$, $p < 0.001$) of intensity of conventional beliefs with preference towards traditional healing practices & duration of illness. A significant decline was observed in both intensity of conventional beliefs and attitude towards traditional healing practices for mental illness after getting some guidance and proper mental health treatment.The Intensity of conventional beliefs before seeking proper mental health services were significantly higher in individuals with LSES (Low Socio Economic Status) than in people in MSES (Middle Socio Economic Status.While social stigma unexpectedly showed no significantinfluence $r = 0.047$, $p > 0.05$.on the preference or delay in treatment method.

Results of this study supported the research questions/hypotheses and found significant influence of conventional beliefs on opting treatment approach for individuals with mental illness. It is concluded that as conventional beliefs were negatively correlated with attitude towards proper mental health services, therefore public awareness programs, legislations and integration of mental health profession and religious teachingsare of great use for treating mental illnesses effectively.

Introduction

The understanding and treatment of mental health problems has gone through a distressing evolution. Historically, mental illnesses were considered as a result of witchcraft, demons or other vague possessions. People with mental illnesses were brutally treated, tortured, burnt, their skulls drilled up and even killed (Farina. 1982). The world then saw a biased inhuman massive movement against mentally sick people to keep them away from marriages in order to stop promoting sick genes. However, with the passage of time as, the understanding and treatment of mental illnesses progress like other fields and the world community started contemplate people with mental illnesses like humans, their proper look after, importance of their needs, feelings, emotions, ego and their disabilities. They got legal rights for treatment, for jobs, and participation in other fields of life particularly in the developed countries. Unfortunately this understanding and acquaintance about mental illnesses and its treatment methods is not widespread as it should be in this fast technological growing world, where we have spread many other good and bad things through media and the social stigma attached to mental illness is still prevailing in many cultures (Edney, 2004; Smith. 2015).

In many research writings it had been evident that stigma associated with mental illness negatively affected every single person with mental illness and their families in different cultures (Corrigan, 2005; Corrigan, & Kleinlein, 2005; Corrigan, Watson, & Miller, 2006; Tsang. Tam, Chan & Cheung, 2003). The adverse effects of stigma in the context of mental health incorporates discrimination during the access to the public services and augments clients' hesitancy to seek professional assistance. Stigma formation can be the result of people's cultural and stereotypical beliefs and operate as an obstacle during the process of treatment and rehabilitation. These ethnically single-minded beliefs were usually known as folk thinks or set theories (Lam, et al. 2010). Haslam (2005) affirmed that it was

vital to recognise common people's conception of mental illness and its allied stigma as these concepts and beliefs inclined the people's help-seeking choices and approaches regarding mental illness, especially when these conceptions instigate in different cultural perspectives.

The term stigma was borrowed by Goffman (1963) from Greeks; who used it to signify physical marks proving something appalling about the moral aspect of the possessor. Using this word for individuals who are suffering from mental illness has serious negative effects at different levels like labelling at public level or labelling oneself or one tries to avoid this labelling (Corrigan et al, 2004; Corrigan & Watson, 2002). Social stigma is spotted as severe social disapproval that result from an individual's departure from social norms. Social stigma is so profound that it overshadows positive social feedback concerning the way in which the same individual holds to other social norms.

Mental illness is ascribed when a type of behavior or experience is evaluated to be abnormal, aberrant, or deviant (Haslam, 2005). Fabrega (1991) declared that the extent of stigma related to an illness depends on its characteristics; and interpretation of disease by the culture and the effects it has on the individual's communal self.

Mental illness is profoundly stalled in a culture of silence, especially in racial minority, refugees and sacred communities (Gilbert et al. 2004; Nadeem et al. 2007). This embarrassment is evidently present in various Muslim communities, where mental illness is frequently underreported and remained undiagnosed because of the apprehension of misinterpretation by mental health professionals and community's criticism and stigmatization (Cinnirella & Loewenthal 1999; Gilbert et al. 2007; Haque 2004; Rethink 2007: Weatherhead & Daiches 2010; Youssef & Deane 2006; Pilkington et al. 2011) and slightly viewed as a psychological and physical illness that have neurochemical imbalance that can be treated through medication and therapy. Some Muslims scholars pointed out

mental illness a metaphysical force like having Jinn or devil possession, brought about by the victim's sinful life and own flaws (Ally & Laher 2008; Haque 2004; Weatherhead & Daiches 2010; Khalily, 2011).

In various cultures including Vietnam, stigma is associated with mental illness for patients and their families. Stigmatization has resulted in repressed sentiments, household troubles, societal inequity and scarcity of mental health resources (Chee Hong 1997).

Labelling Theory

American sociologist Becker (1963) originally put forth the labelling theory to elucidate criminality. Shortly after Becker coined this theory, it was used to describe attitude of people towards individuals and their mental illnesses.

Likewise this theory is recognised as *Social Reaction Theory.* Labelling theory founds the understanding that abnormality is not exclusively linked to personality factors of the individuals, expecting unusual doings and social surroundings particularly people's attitude also has some contribution to put an individual or a group of people under the flag of deviants, delinquents or non-conformists. This theory propagates that the bulk of people of a society apt to put the minorities under an umbrella of deviant. The theory also gives an idea that how the self-identity and behaviour of the individuals can be influenced by others. Szasz (1970) called it an abuse, as "harming persons categorized as insane was essential function of institutionalized psychiatry". The actual idea of mental illness was notably declared as a myth by Szasz (1961). In so far as both Szasz and Laing did not agree to the concept of mental illness as a biological reality but claimed that certain social processes are responsible for these terms and side effects of medicalisation behind it (Szasz. 2008).

Existence of shame associated with mental illnesses is a permanent impediment for the people with mental illness. Erving Goffman, a sociologist firstly explained clearly that the social stigma could play a contrary part beside the person with mental illness or it perilous the life of these people if stigmatization process is found to be unchanged in the community (Goffman, 1963; Fabrega, 1991; Philips & Gao, 1999). Stigma has been indisputably acknowledged as an adverse component to the path and development of severe mental illness amongst the mental health professionals.

Stigma has a chain of connected mechanisms as explained below (Link. et al. 2006);

1. The recognition procedure of the explicit and implicit individual dissimilarities by the people may include race, IQ, sexual orientation, medical conditions and diagnosis.
2. Course of stereotyping includes labelling of a person with undesirable characteristics.
3. Groups can separate general population from the labelled population by placing the label of stigmatised group to them and the remaining people as us.
4. The labelled individuals begin to experience discrimination and hence lose privileges of socially equal status.

Link et al. (2006) added to develop an improved labelling viewpoint which indicates that stigmatised persons identify that an undesirable label has been associated to them and the other people in community, they are being considered as less reliable and smart while, more precarious and useless. The altered labelling theory illustrated that persons who have had the experience of hospitalization for their mental illnesses would act less confidently and more passively in front of others or become isolated. The affects of labelling might be more demanding to individuals with psychiatric illness and their significant others. Troubles are in the forms of isolation, rigid community system, compromised life standards, poor self-

esteem, low self-efficacy, joblessness and monetary reliance (Link. et al. 1995; Link. 2006; Link. et al. 1989).

In Conceptualizing Stigma, sociologists Jo Phelan and Bruce Link (2001), interpreted stigma as the union of four different aspects; differentiation of various segments of society, linkage of different social demographics to prejudices about stigmatised individuals, the progress of an us-versus-them ethic and disgracing the individuals who are labelled and placed in the mentally ill category.

Eventually, stigma is about social control. Consequently it is a social phenomenon. For labelling, one must have a stigmatizer and someone to stigmatize. This is a dynamic social relationship. As stigmas occur from social relationships, the theory emphasized, not on the existence of deviant conduct, merely on the perception of certain traits as deviant by another party. The theorists of stigma gave little importance on another individual perceiving and knowing about the stigmatized mannerisms. Stigma is necessarily permeated with relations of power. Stigma facilitates to control deviant inhabitants and encourage compliance as they remain settled having matched beliefs and attitudes towards stigma coupled with mental illness. Agreeing to Fabrega's (1991) discovery, the stigma is not developed due to the illness only but also on the standpoint of dominant cultural & religious beliefs or ideology. If the beliefs are inconsistent or not testable then it leads to mal practices.

The word conventional means things, habits, beliefs, ceremonies etc that are based on or in harmony with general contract, use, or practice (American Heritage Dictionary, 2011), and to follow the traditions and proprieties, especially in a way that lack originality (Collins English Dictionary, 2003).

In this study, conventional beliefs refer to the unjustified interpretations of solely psychiatric disorders due to which family members of the patient wander for ruling some

clarification & treatment from traditional healers, which not only results in impediment of treatment, but also the family and patients suffer and remain untreated. Mental illness is frequently misunderstood in different cultüres due to multiple reasons and hence mistreated by traditional non-empirical methods, which results in patients' chronic suffering. The prevailing unscientific and lay beliefs regarding mental illness not only affect the basis and coping strategies used for a troubled behaviour but these beliefs are also negatively affecting deterrence, timely interference and community treatment. In order to improve the condition of mental ill individuals within any culture, we need to properly understand the damaging attitude and a supporting positive stance of people in that culture. Multiple cultures have their own explanation for psychiatric disorders. As in the history of Vietnam, those associated with mental ailments have been misjudged and maltreated (Chee Hong, 1997). The rationale prevailing in different cultures include deep affiliation with religion but least knowledge of accurate religious teachings, lack of consciousness, gender and age differences, socioeconomic discrepancies, and lack of education (Dein et al. 2008; Khalifa et al. 2011).

Religion is always given the central importance in defining health and disease (Sheikh et al., 2000). Muslims are especially vulnerable segment of the population in terms of mental health (Maynard, 2008) as other communities in the world. Based on the beliefs of some people mental illnesses are considered to be the result of going away from the right path or possession by demons (Lowenthal & Goldblatt, 1993). Psychological problems such as anxiety and depression are repeatedly regarded as indicative of a rickety spiritual heart by various Muslims (Weatherhead & Daiches, 2010) and that mental illness can be due to either a flawed relationship with God and a punishment from Him (Al-Krenawi & Graham, 1999) or due to the deficiency of faith or praying (Weatherhead & Daiches, 2010). Cinnirella and Loewenthal (2001) inferred that depression is believed to be impracticable in a true religious

person, and clients can use a range of religion based coping strategies without telling their doctor as there may be distrust with religious sources regarding psychotherapists and psychiatrists."

People in Vietnam believe in multi lives of an individual, and they believe that if a person is facing any problem in present life is in fact the consequences of bad deeds in previous life. Now if a person is having some kind of mental illness so that is associated to his or his elders previous sinful life. The mental illness is considered as a punishment for him and his family equally bearing all the abnormal behaviours (Nguyen, 2003).

Mental illness is also coupled with black magic done by other people. Black magic refers to the asserted ability to alter things by paranormal means with the intention of causing harm or destruction. Evil eye is another said cause of mental illness that refers to the ability of mankind has to inflict harm on others either emotionally or physically by giving them an envious look. Some individuals in Muslims community also consider in black magic and evil eye (Khalifa, Hardie, Latif, Jamil, & Walker, 2011). People believe and talk about the evil eye. Some of them do much more things to protect their own selves and their family from evil eye (Johnsdotter et al., 2011)

Nonetheless, the scope to which beliefs about Jinn, black magic and evil eye can have impact on health behaviour among Muslims community remains argumentative (Dein et al., 2008).

The idea of jinn or genies has started influencing western conception through different old stories like story of Aladin. Muslims believe in the existence of jinn and their hidden world from human eye, and also believe that they have the capability of harming humans both physically and mentally in the form of possession (Sakr et al., 2001; Al-Ashqar. et al., 2003).

According to the definition of Littlewood (2004) possession is a state when jinn or any other supernatural force enters into human body and control or change the actions of that person different from the routine actions or behaviour of the person. For others, it would be a manifestation of a transformed state of mindfulness.

Jinn possession is more commonly reported in United Kingdom by Pakistani, Bangladeshi nationals and people from Middle East and North Africa (Littlewood, R. 2004). Another hypothetical source of craziness is control by annoyed "familial spirits". Families avoid upsetting their elders due to the threat of the costs (Luntz, 2001)

Jinn are supernatural spirits produced from a smokeless flame of fire which have a harmful manipulation on the mind and the body. Jinn possession is considered as a misery over which the recipient has tiny or no control (Ghubash & Eapen, 2009). Once contained by the body, Jinn alter mood states instigating anxiety, weeping, anhedonia and emotional lability (Al-Bahrani, 2004).

Muslims deem in the existence of three detached, but parallel worlds of Mankind, Angels (messengers of God) and Jinn. According to the Islamic belief, Jinn are creatures who obscure themselves from Mankind, so they observe us but they cannot be seen. Jinn have the equivalent requirements as human beings like they eat, drink, procreate, reproduce and pass away (Al-Ashqar, 2003).

The extensively accepted belief among Muslims is that Jinn are competent of causing bodily and intellectual harm through possession (Khalifa & Hardie, 2005), when a para human force enters into an individual which then controls him (Dein, 1997; Littlewood, 2004). In the Arabic World, where the majority inhabitants are Muslims, belief that Jinn can go through the human body and cause mental illness, with symptoms such as forgetfulness,

lack of energy and gloomy fears being frequently attributed to Jinn and evil eye (El-Islam, 1995). Hence, patients exhibit psychiatric symptoms believe that they are possessed by Jinn, typically have underlying physical or mental health problems (Bayer & Shunaigat, 2002; Afzal, 2014).

Arabic phenomena of Jinn possession is widely accepted, although Jinn can be there at any time of susceptibility, possession during the postnatal period is widespread. Remarkably, the symptoms of Jinn possession reflect those experienced by women suffering from postnatal depression in Western Cultures (Oates et al., 2004). These symptoms are hardly ever considered to be due to postnatal illness but instead the consequence of the Jinn's influence (Ghubash & Eapen, 2009).

Conventionally epileptic fits are associated with jinn possession on the basis of some sacred beliefs. These viewpoints and false impression about this illness are growing even now as side effects of rigid socio-cultural settings. It is of great importance if one believe that epilepsy is in fact due to possession. Even in intensely different and distant cultures such as the Greco-Roman, Judeo-Christian, Islamic, Hindu, and Voodoo conduct, epilepsy has constantly been seen as an infliction by a supernatural power, be it a God or a demon

This misconception is prevailing in many categorically different cultures i.e. in Roman, Christian, voodoo, Hindu and Islamic cultures. In almost all these cultures epilepsy is considered to be the result of controlled by some para human force (Magiorkinis et al., 2010). Epilepsy was considered as a holy malady in Greeks linking it to their beliefs that the condition is in fact due the visit of god through that individual (Temkin, 1971). Christians went behind the beliefs mentioned in Bible regarding demons possession of humans. Generally epileptic patients have explained their fits as sacred experiences, mainly the signs of depersonalization, derealisation and autos copy linked through different states of temporal

lobe, propagating the mistaken view that it is not a biological disease (Temkin, 1971; Devinsky et al., 1989).

Previous researches showed that the most of the participants held belief in the actuality of Jinn and Jinn possession (Al-Habeeb, 2004; Hussein, 1991; Dein et al, 2008). In the Islamic literature there are several evidences that can be used as a proof for the real existing of jinn as a distinct creature, according to some scholars believing in jinn is a part of the faith. Some scholars have claimed that the Qur'an discusses spirit possession in connection with mental illness (Dols, 1987; Haque, 2004).

The most explicit illustration of the connection between possession and mental illness in the Qur'an comes from the nonbelievers replying to Hud (A.S), saying that all we can say is that one of our gods may have imposed some harm on you. Pickthall interpret this as; our gods hath possessed thee in an evil way, even though the expression does not contain any words with the jinn root. In the Qur'an, insanity is connected to sin and misguidance. Truly the evil are misguided and quite insane. The use of insanity in these phrases seems to be implying spiritual madness, rather than a physical condition. Again, much like the Qur'an's debate of spiritual heart disease, wickedness is attached to misguidance and spiritual insanity. The implication is that by being misguided and losing their footing from the straight path, disbelievers have also lost their minds. Spiritual sanity is found in following the path to God. As Qur'an for themes related to the terms jinn, Satan and madness capitulated no direct connection between spirit-possession and mental illness (Islam et al., 2014).

Majority of those who considered their illness as the possession by jinn possibly be illiterate (Mullick, Khalifa, Nahar& Walker, 2012; Dein, Alexander & Napier, 2008; Afzal, 2014), they persuade to get from low socioeconomic locale, and typically have basic bodily or mental well-being difficulties (Bayer & Shunaigat, 2002).

Understanding of the fundamental causes of mental illness hang between biological and para human forces. This understanding differs with educational level and financial position of a person. In rural areas where literacy rate is considerably low people have many different para human justification for mental illness like possessed by evil spirit, black magic or horoscopic misalignment (Lien, 1993). Lesser education, female gender and older age have been established to be predictors of the belief in paranormal roots of mental illness (Dein et al. 2008; Khalifa et al. 2011).

Various worldwide studies have verified absence of awareness concerning psychiatric problems like epilepsy amongst the common people and even among health care experts (Jensen et.al., 1992; Al-Adawi, et al., 2001). Persons with psychiatric disorders experience trouble with work, learning and public dealings (Jacoby, 1995; El-Hilu, 1990). Erroneous and incorrect opinions about mental illness have negative impacts on societal approval of people with psychiatric disorders (Kim et al., 2003). A study from Saudi Arabia revealed that majority of people in Saudi believe in Jinn possession even now, consider epilepsy as its result (Obeid, 2012).

As compared to male subjects, more female believed in the actuality of jinn and mentioned religious personalities as the treating authorities for such problems (Muhammad et al., 2012). Different females described their understanding and perception of the appearance and activities of Jinn. The Jinn appeared to be the malevolent leech accountable for ills and bad luck. It was this Evil that could hold new mothers after the birth of their babies and emerged synonymous with the Western concept of Postnatal Depression. This evil concept of Jinn was a shared structure with similar descriptions of both how the Jinn seemed and the effect it had on new mothers. Jinn were viewed as monstrous creatures; powerful and destructive beings full of fire and wrath. Jinn possessed a new mother distressing both how

she felt and how she acts towards her baby, husband and relations. Jinn possession was supposed to cause great sadness, anxiety and emotional pain, drawing clear correspondence between the emotions experienced by women with postnatal depression in Western countries (Beck, 1999).

Women's conversation of their Jinn possession were same like the sign and symptoms experienced by Western women suffering from postnatal illness including feelings of sorrow and loneliness beside self-blame and guilt. Notably, it's similar to postnatal depression; many of the women disapproved these feelings as being a normal occurrence after childbirth (Hanley & Long, 2006).

As it was surveyed in Ho Chi Minh City, the low educated people ascribed mental illness to ordinary movements. It is believed that mental stresses or emotional burden due to effects such as distress, deprivation for love, or simply thinking too much, create weak nerves that make one vulnerable to a psychiatric disorder (Nguyen, 2003)

Olusesi (2008) conducted a study of beliefs about psychosis and marital instability among Nigerian immigrants in USA, revealed that participants with highest level of education were less likely to believe in bizarre causations for psychosis and marital volatility than those with lower levels of education. Respondents with higher educational success were less likely than those with lower achievement to believe in jinn possession or Jinn, black magic and evil eye that it could be the cause of mental health problems. The highly educated participants, compared to illiterate participants, very rarely believed in jinn possession or black magic and evil eye as harming agents to human beings (Muhammad et al., 2012).

There are multiple conventional treatment strategies used for misconceived psychiatric disorders and mental illnesses (Khalily, 2011). These healing practices are totally

based on the consideration and description of the causes behind such mental illnesses in different cultures.

Like in Vietnam, people who believe in paranormal causes of disorders try to find and get the help from astrologers, bonzes (Buddhist religious teacher), and magicians. Old-fashioned remedies are highly valued amongst the common people than professional mental health service due to its extensive history of incorporation into Vietnamese culture. Patients can easily find old fashioned healers for the treatment of their illness (Khalily, 2011). Traditional healing practice is cheaper and affordable as compared to psychiatric treatment procedure and medication. Due to the abundance of traditional healers it is easy to approach them spending least money and time in local areas instead of spending more money to avail psychiatric treatment in far-away cities. The most important advantage in accessing traditional healers is that there is no fear of labelling as they treat many diseases other than mental illness (Khalily, 2011). Psychiatry is generally seen as a last choice (Nguyen, 2003).

In states, where Muslims are in majority, it is a common practice to approach faith healers for mental illness at priority basis for those who believe signs of such illnesses are due to the jinn possession or deviance from the right path (Hussein, 1991).

Faith healers practice a variety of spiritual mediations to cure the discomfort caused by para normal forces, the commonly practicing methods are *Ruqyah* (in quest of shelter with Allah through rehearsing specific stanzas from Quran) and *Dhikr* (commemoration of Allah) (Khalifa & Hardie, 2005). In accumulation to these, Al-Habeeb (2004) stated numerous other curing modalities containing regular recital of supplications, exorcism physical penalty, cautery use of herbal solution, drinking of the tahliil solutions (sacred water, frequently termed as ashar water), with the supremacy to treat and restore from the illness, this sanctified water is purified through reading Quran and prayers wafting or spitting into the

water. An additional means to generate this curative water is to pen Quran aaya with dark ink (usually a mixture of coal and milk) onto a slice of timber, and then rinse the slice of timber in water (Johnsdotter et al., 2011), however, this practice is not common in Muslims community but prevail in some Muslims sub culture .

Muslims possibly believe that religious involvement such as reciting the Qur'an can heal the emotionally troubled individuals, therefore could scare them from approaching primary care. For women in Islam it is more critical and central problem who are dependent on support from relatives and scholars for many such problems (Abu-Ras& Abu-Bader, 2008) mainly due to the deficiency in financial freedom, or less familiarity with services (Abu-Ras, 2007). The environment and the specified prayers in a religious healing method are equally critical components of the remedial procedure. Such healing practices are carried out in places like a church, a mosque, a shrine, house of faith healer or some other holy place.

In several Arab nations, people who consider their family members' illness as the consequence of demons possession, black magic or some other paranormal forces they immediately try religious practices to heal the illness of their family members. These practices contain different customs like going to the graves of eminent religious persons, sessions with knowledgeable faith healers (Al-Asyad., 2004). Faith healers use Ta'wiz, which is in fact the holy verses from Quran written on a paper wrapped up in cloth or skin, and other method is writing the verses of Quran on a plate with washable ink, the patient wash the plates in clean water and drink it. Such treatment exercises with the person identified with schizophrenia revealed his personal Ta'wiz, which was prepared by a spiritual specialist (Johnsdotter et al., 2011).

The view point of some of the Muslim community, specifically women that mental illnesses can be treated through religious practices, forbid them to access proper mental health care; instead leading them to approach their dear ones and spiritual healers for help

(Abu-Ras & Abu-Bader, 2008). While religiosity is considered to be a protective factor for mental illness, as religious Muslims reporting better mental health than non-religious Muslims, this could reflect under reporting of mental health difficulties due to stigma of poor religiosity (Abdel-Khalek, 2008).

Most patients sought cure in both the medical realm as well as the spiritual (Dols, 1987). More recent chronological data include those written about Masud Khan, a man born into a family of Muslim feudal royalty in India in 1924 and suffered from undiagnosed bipolar disorder along with usual was examined by many major figures in Western psychoanalysis such as Anna Freud (Hopkins, 2006).

Numerous individuals said that if the patient is not much serious and does not harm self or any other person, so the family members do not disclose his illness to other people due to the fear of labelling and disgrace. Recitation of Holy Quran is mainly considered as the best way of protection against mental illnesses. Family members and friend in group setting or religious scholar him-self recite the whole Quran or some specific Surah of Quran. In Sweden the proper mental health care was considered as the last option after the failure of all other conventional methods of treatment. Approaching proper mental health care was considered to be the distressing decision after the severity in condition of mentally ill individual, who was now potentially harmful to self and others (Johnsdotter, et al., 2011).

Many research studies publicised that a large proportion of Muslims living in western countries avoid consulting mental health professionals (Hedayat-Diba, 2000; Hodge, 2005; Mahmoud, 1996) due to the dissimilarity in their philosophies and insufficient level of understating of the serving authorities about Islamic principles in their curing procedures. As the beliefs of serving professionals and Muslims over there are widely different therefore they feel reluctance and discomfort receiving such help which is against or different from

their beliefs. Muslims appear to be underrepresented in deliberately accessed services, like counselling or outpatient care (Weatherhead & Daiches, 2010) with formal services only being accessed at decisive times. Perceptions of reputation appear to play a role in this decision process, and seeking help is a sign of flaw by other members of the community, which in turn affects one's reputation (Weatherhead & Daiches, 2010).

Many prominent Islamic scholars, including Ishaq ibn Imran, Al Razi and Ibn Sina, marked medical texts pertaining to insanity, demarcating three major categories of mental illness, such as canine madness, lycanthropy and phrenitis (Dols, 1987). Ibn Sina discarded the belief that mental illness arose from supernatural origins (Pridmore & Pasha, 2004). These Muslim scholars did not support the view 'epilepsy as a result of jinn possession', however it is interesting to know that they used spiritual ways for curing such disease (Temkins, 1971).

Regardless of the favour of few researches to the significance of old-fashioned remedial practices, many Muslims do not believe in this type of healing nor consider it as Islamic, which in these instances would make its use unsuitable and even expelled in certain Muslim countries (Al-Issa, 2000). Additional, evidence proposes that Islamic traditional healing works mainly for treating neurotic symptoms, as opposed to severe mental or physical illness where it will fail (Razali, 1999; Khalily, 2012).

A study proposed that when respondents were enquired about the kind of treatment they would imply for an individual with epilepsy, less than one-half of the respondents (49.4%) would seek medical counsel from a doctor, with reading the Quran and taking herbal medicine being the next two most cited kinds of treatment, which has also been reported in Kuwait.18 Furthermore, 16.2% of respondents believed that epilepsy was not curable, which is a reflection of the cultural beliefs in Saudi Arabia (Alaqeel et al., 2013).

Rationale of the study

Historically mental illness has been misperceived misinterpreted and hence maltreated. Mental illnesses were associated with possession by demons and other supernatural powers. Mentally sick individuals were labelled according to the cultural and traditional beliefs. Both the misperception and labelling attitude of society lead people to show reluctance to express about a family member's mental illness and seek professional help. In such condition the families tried to find alternative and least stigmatized treatment approaches. In this situation the patient remained at risk, because the unscientific and traditional healing approaches were either brutal in old times or were the ways which instead of recovery worsened the condition of the patient. In the Scenario of Pakistani community where Traditional healing practices i.e. peeri/faqeeri, jadu/tona are predominantly practiced for psychiatric disorders.

This study was designed to find out the possible links between perception regarding family members' mental illness and its impact on attitude toward professional treatment methods or traditional healing practices of the population of twin cities i.e. Rawalpindi & Islamabad. The findings of the study is helpful to know about a certain perception development and the underlying causes. The study is useful in its nature to highlight the importance of guidance and professional help about the mental illness. It is also beneficial to convince mental health professionals and religious healers to introduce new methods of treatment by integrating both mental health profession and religion. Researches on social stigma and beliefs about mental illnesses has been conducted in many other countries, But the researcher found no more than two or three researches conducted in Pakistan on social stigma associated with mental illness. Therefore, it was a dire need to know about the conventional beliefs prevailing in our culture along with social stigma regarding mental illness and the reasons for approaching traditional healers.

The following hypotheses were framed;

a. Individuals with high level of social stigma & conventional beliefs tend to have negative opinion about their family members 'support for treatment.

b. Positive output of professional treatment for mental illness can help change the family members' conventional beliefs & attitude regarding mental health services.

c. Individuals holding conventional beliefs prefer to avail traditional healing approaches, for their family members with psychiatric disorder

d. There is a significant gender difference in the level of conventional beliefs regarding family members' psychiatric disorder.

e. Individuals with higher religious affiliation tend to hold more conventional belief than the less religious affiliation regarding their family members' psychiatric disorders.

f. Individuals with lower socioeconomic status hold more conventional beliefs as compared to people with higher socioeconomic status.

g. Individuals with high socioeconomic status are more conscious about social stigmatization as compared to individuals with low socioeconomic status, which ultimately lead to delay in treatment and recovery of mental illness

Method

Research Design

This research was based on mixed research design or triangulation method (Donzin, 1989). Social stigma scale was used for collection of data regarding social stigma associated with psychiatric disorders and a semi structured interview technique used for the collection of data about conventional beliefs and traditional healing practices.

Focused Group Discussions (FGDs). FGDs was conducted with the aid of moderator and note taker. Focused Group Discussion was carried out among five experts of mental health profession. FGDs was basically used to uncover the topic and to make it clearer. It helped to build greater rapport throughout the fieldwork.

Sample

A purposive sampling including (N = 50, Male = 32, Female = 18) of the care takers (guardian and immediate care taker) of the patients.

For the purpose of this study the care takers mean the persons/individuals who took care of another in the general sense or in the sense of a caregiver or looked after someone who was severely physically disabled and/or mentally ill and was unable to care for themselves. They could be family member or any other responsible for the look after of a mentally ill person respectively. Guardian was the person who had the right to take decision about the important matters of an individual. As in this case the decision for the way of treatment was of immense importance; therefore it was necessary to take the view of the guardian about the way of treatment they avail and the reason of that decision as well.

Those individuals' having diagnoses of single or dual psychiatric disorders were included and currently under treatment. Exclusion criteria was the care takers of undiagnosed and un-registered patients.

Instruments

Demographic Information Sheet. Demographic information sheet was used to collect information concerning the subjects' gender; age, marital status, education, employment, family system, birth order, previously approached mental health services and socio economic status etc.

Discrimination Devaluation Scale. Perceived Public Stigma subscale of Discrimination Devaluation Scale is consisting of twelve items developed by Link and colleagues (1987). This scale is basically instrumental to measure the stigma associated with mental illness. It is a five point Likert type scale. Response categories ranged from "strongly disagree" to "strongly agree". Cronbach's α of the scale is 0.89.

The back translation and validation of the Stigma Scale was conducted in Urdu version in the present study for data collection of the main study. Psychometric properties were established and standardized procedure was followed for the translation and validation of the scale. Reliability (α) of the scale was calculated as 0.6.

For Conventional Beliefs the following measures were used;

Semi Structured interview. Semi structured interview was conducted to collect data about the conventional beliefs they held about different psychiatric disorders. It was totally detailed interview through which we uncovered the Conventional Beliefs and made it comprehensible. It was very helpful in maintaining the rapport throughout the research and the fieldwork. In-depth interviews were conducted to obtain true thinking patterns of conventional beliefs of caretakers towards the psychiatric disorders. Researcher also interviewed that why caretakers were adopting the particular beliefs and practices, and what *were* the reasons behind the establishment of certain beliefs.

1. Interview guide. For convenience the researcher constructed a list of question asked from the participant and the topic to be discussed. This list helped out in the form of points of guideline for interviewer. An interview guide was developed with the help of supervisor and detailed obtained from focus group discussion to take interviews from the patients, practitioners, and the caretakers.

Procedure

The sample was collected from hospitals, psychiatric units, and private clinics of Rawalpindi and Islamabad. The participants were approached after prior permission from concerned authorities of Ethical Committee for Research in Social Sciences, International Islamic University, Islamabad, Institute of Psychiatry, Benazir Bhutto Hospital Rawalpindi & Psychology Clinic at Integrated Health Services Hospital F-10 Islamabad. The authorities of these institutions were briefed about the aims and the process of the study. Informed consent was taken from the participants in written form, confidentiality were kept intact. After data collection the researcher thanked the participants. Data was collected in group settings. SPSS software (version 22) was used for the analysis purpose.

Results

Table 1

Socio-demographic characteristics of caregivers in the study population (n = 50)

Variables	Category	N	%
Age	20-40	34	68
	40+	16	32
Gender	Male	32	64
	Female	18	36
Marital status	Married	31	62
	Single	18	36
	widowed	1	2
Relation with patient	Parents	13	26
	Siblings	21	42
	Spouse	9	18
	Other relatives	7	14
Education	Illiterate	2	4
	Primary	8	16
	Middle	16	32
	Metric	9	18
	Above metric	15	30
Occupation	Unemployed	4	8
	Self-employed	21	42
	Private employed	15	30
	Govt. employed	10	20
Income	Below (20000)	11	22
	Above (20000)	39	78
Religious affiliation	Least affiliated	4	8
	Moderate affiliated	40	80
	Deep affiliated	6	12

Table 1 showed that majority of the care givers age range 20 – 40 years were 68%, above 40 years were 32%, male were 64%, female were 36%, married were 62%, single were 36% and widowed 2%, 26% of care givers were parents, 42% were siblings, 18% were spouse and 14% were other relatives of patient. Among these care givers 4% were illiterate, 16% had primary, 32% middle, 18% metric and 30% were above metric level of education. 8% of them were unemployed, 42% self-employed, 30% private employed, and 20% government employed. 22% of care givers belonged to low socioeconomic status and 78% were from middle socioeconomic class. Of these 8% had least, 80% moderate and 12% deep religious affiliation.

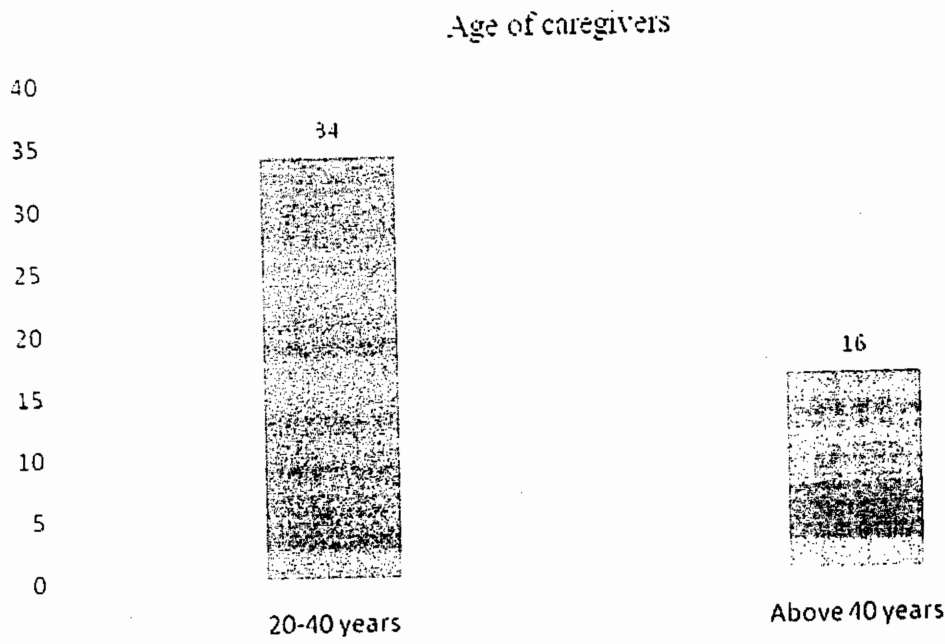

Figure 1. Graphical representation of age of caregivers in the study population.

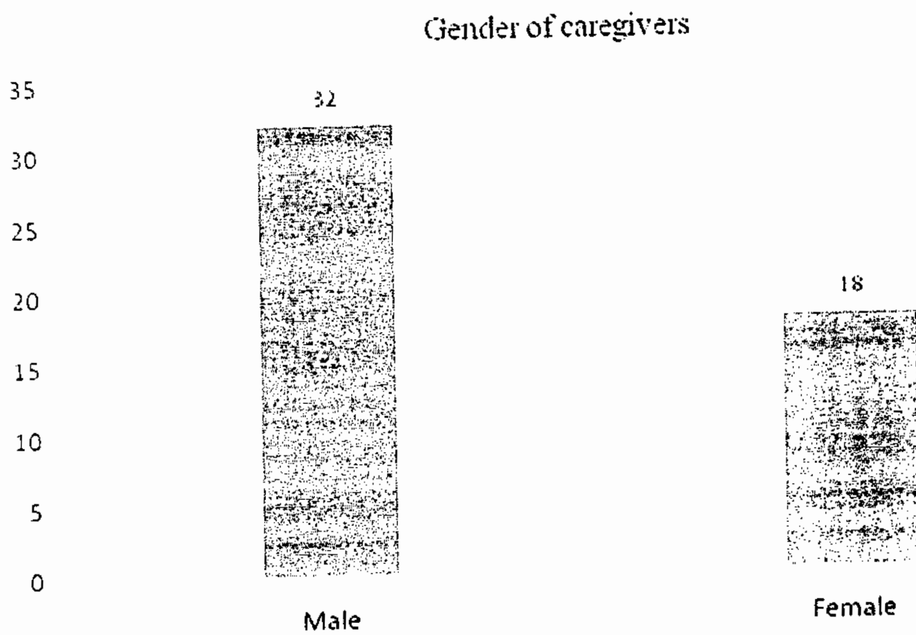

Figure 2. Graphical representation of gender of caregivers in the study population.

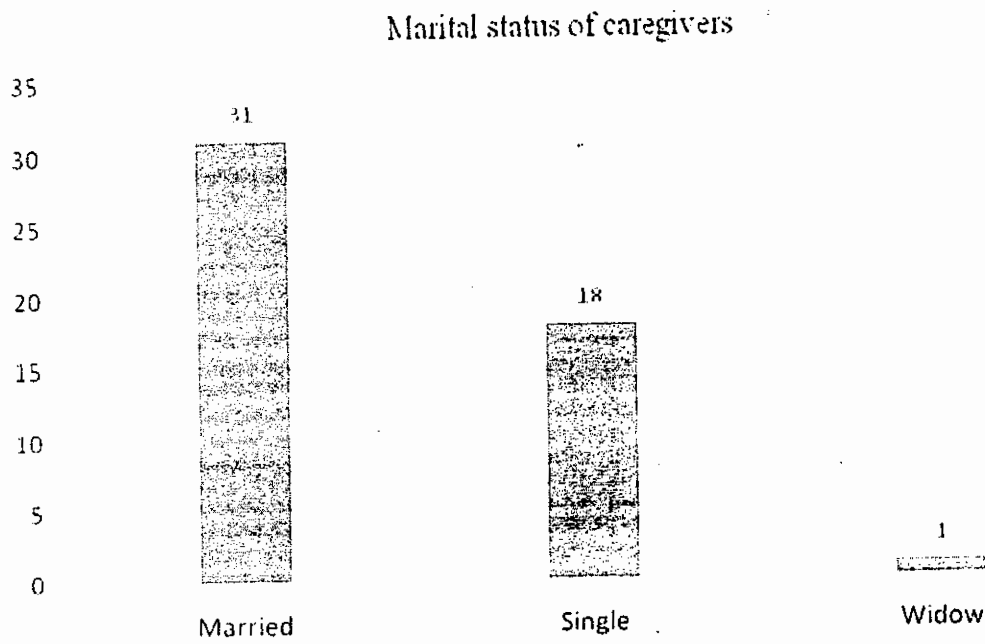

Figure 3. Graphical representation of marital status of caregivers in the study population.

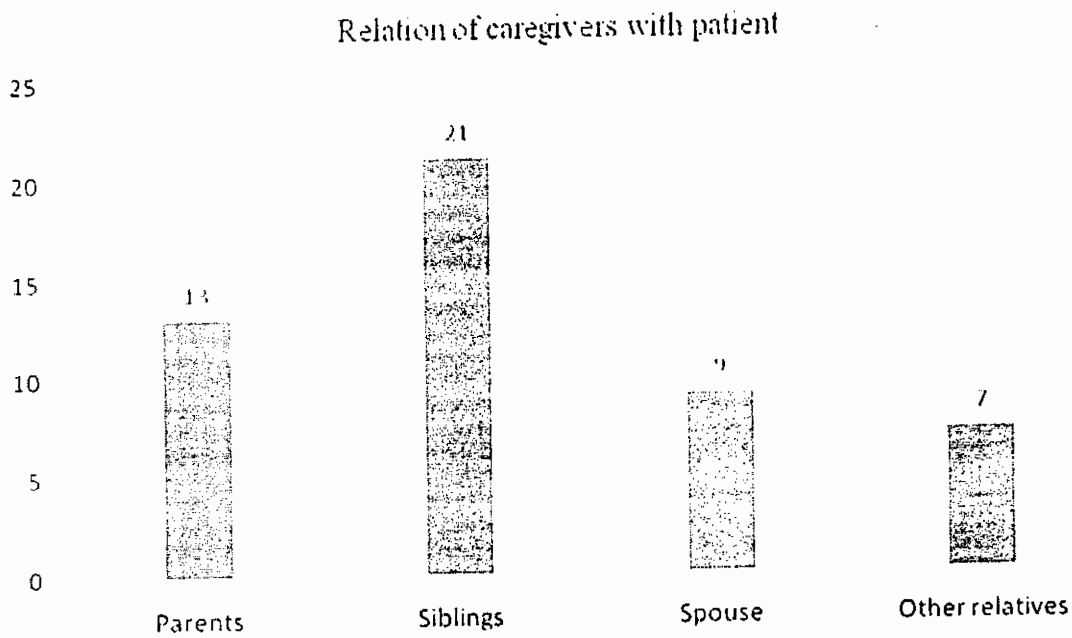

Figure 4. Graphical representation of relation of caregivers with patient in the study population

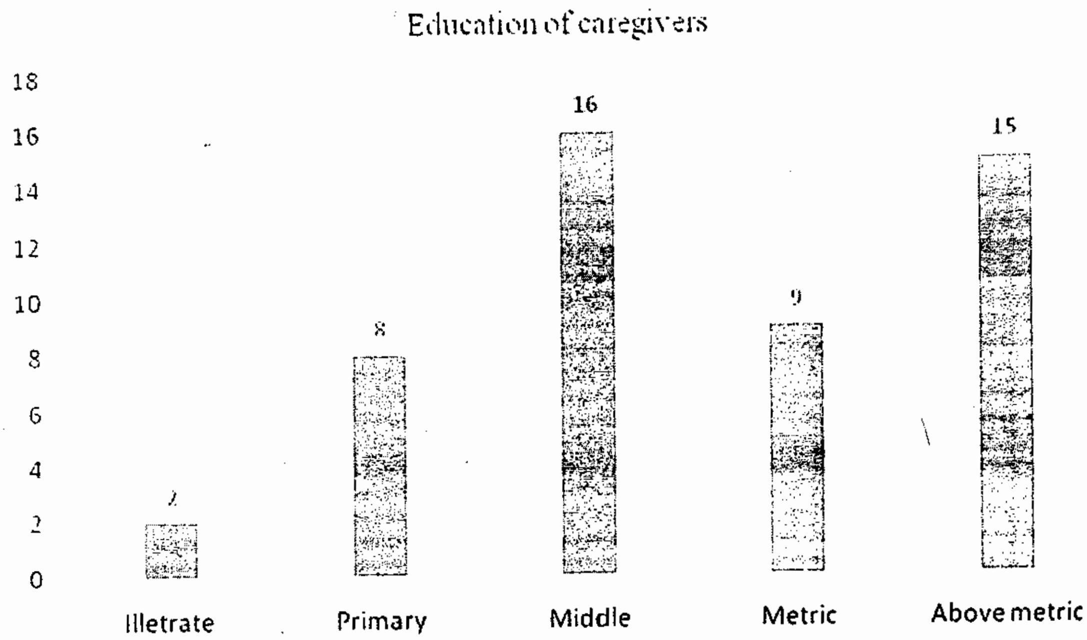

Figure 5. Graphical representation of education of caregivers in the study population

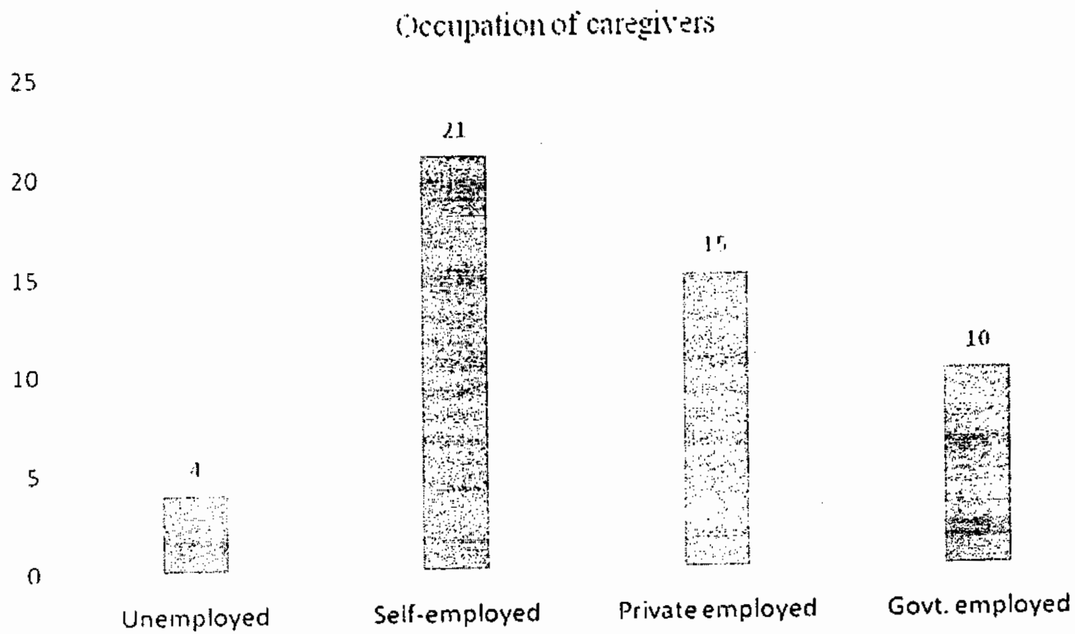

Figure 6. Graphical representation of occupation of caregivers in the study population

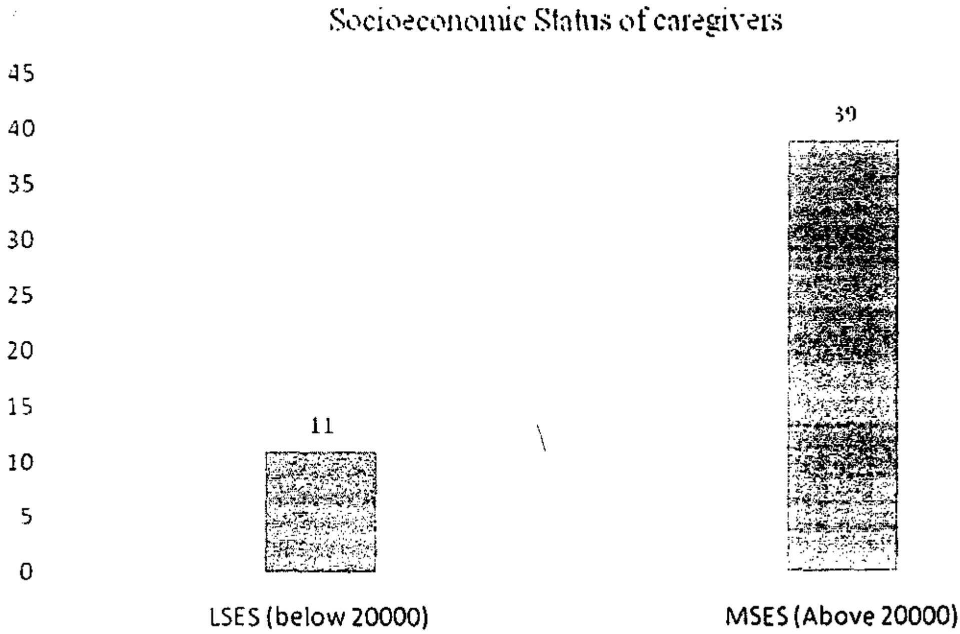

Figure 7. Graphical representation of socioeconomic status of caregivers in the study population

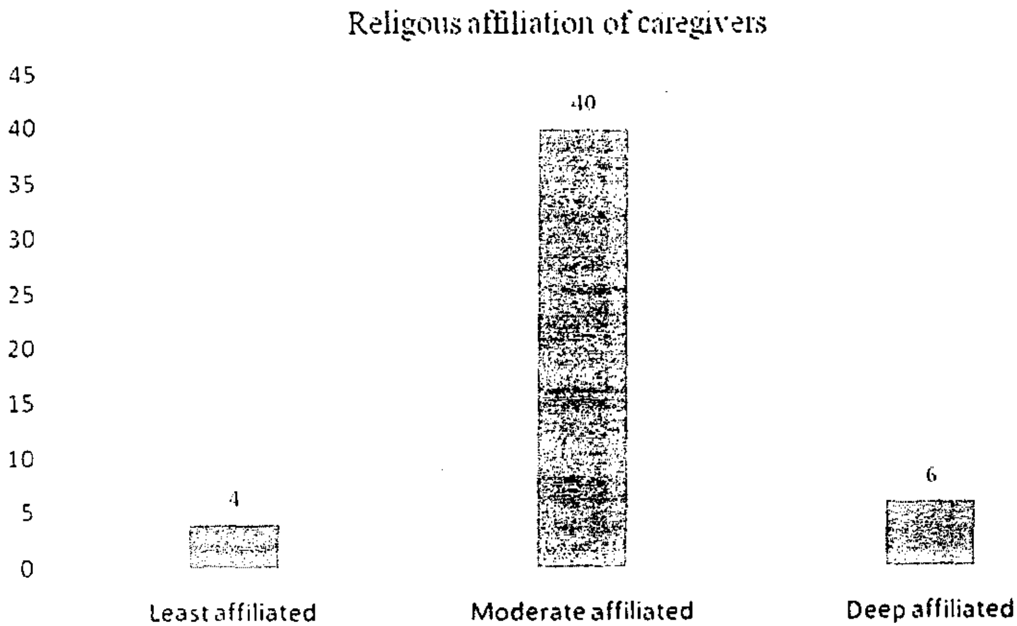

Figure 8. Graphical representation of religious affiliation of caregivers in the study population

Table 2

Socio-demographic characteristics of patients in the study population (n = 50)

Variables	Category	F	%
Age	7-19	6	12
	20-40	36	72
	Above 40	8	16
Gender	Male	26	52
	Female	24	48
Parents	Alive	41	82
	Dead	9	18
Siblings	Below 5	25	50
	5-10	21	42
	Above 10	4	8
Education	Illiterate	10	20
	Primary	6	12
	Middle	11	22
	Metric	14	28
	Above metric	9	18

Table 2 showed that patients between age ranges 7 – 19 were 12%, 20 – 40 were 72%, and above 40 years of age were 16%. 52% were male and 48% were female patients. 82% of patients' parents were alive and 18% were dead. 50% of patients had below 5 siblings, 42% had 5 -- 10, and 8% had above 10 siblings. 20% of patients were illiterate, 12% primary, 22% middle, 28% metric and 18% were above metric level of education.

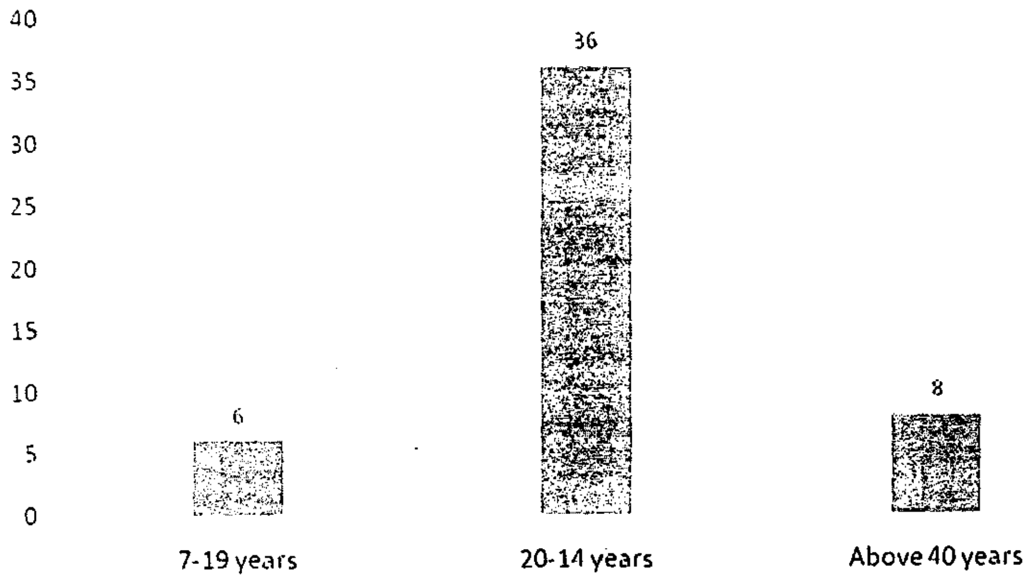

Figure 9. Graphical representation of age of patients in the study population.

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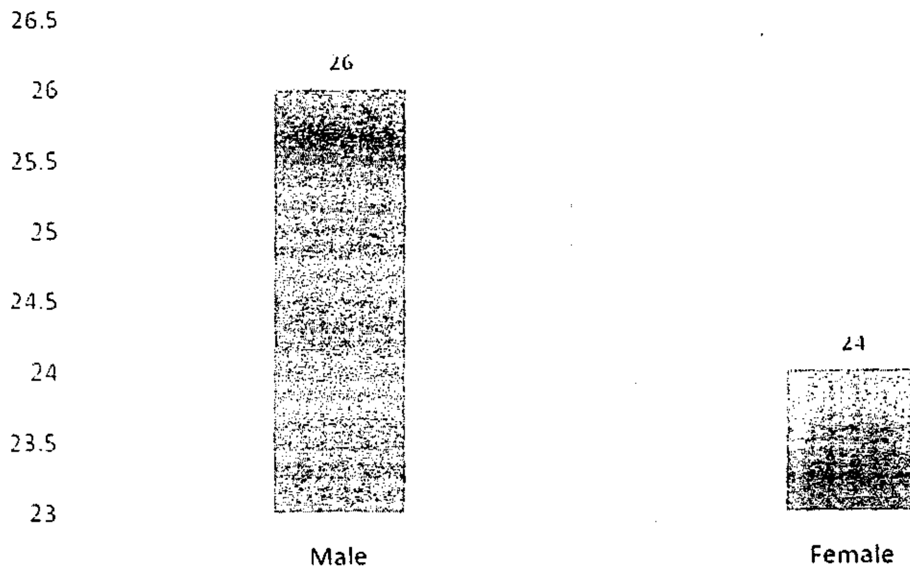

Figure 10. Graphical representation of gender of patients in the study population.

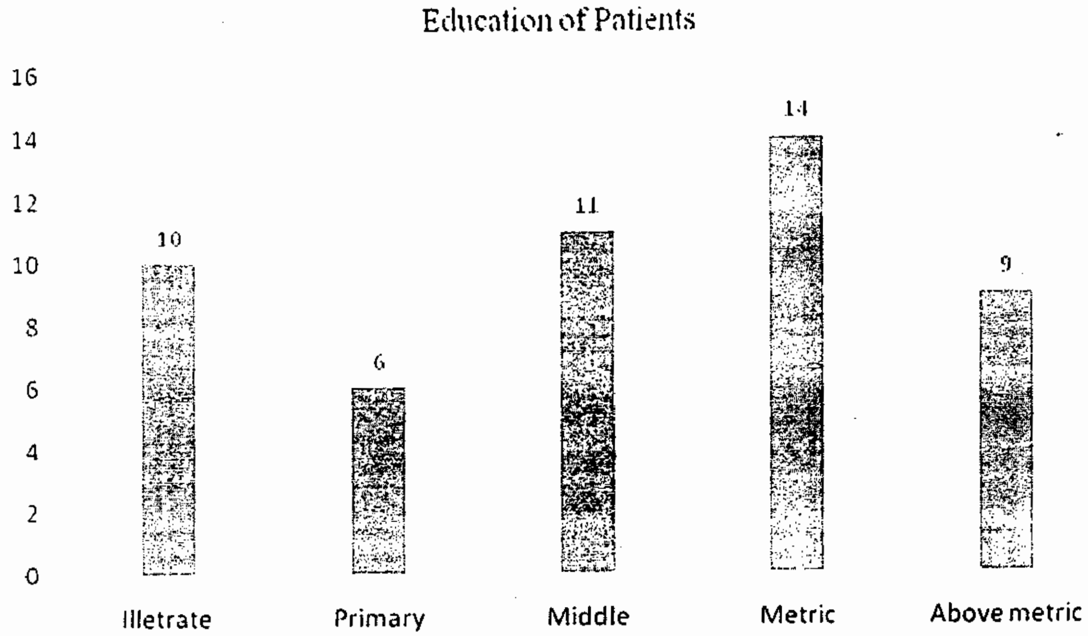

Figure 11. Graphical representation of education of patients in the study population

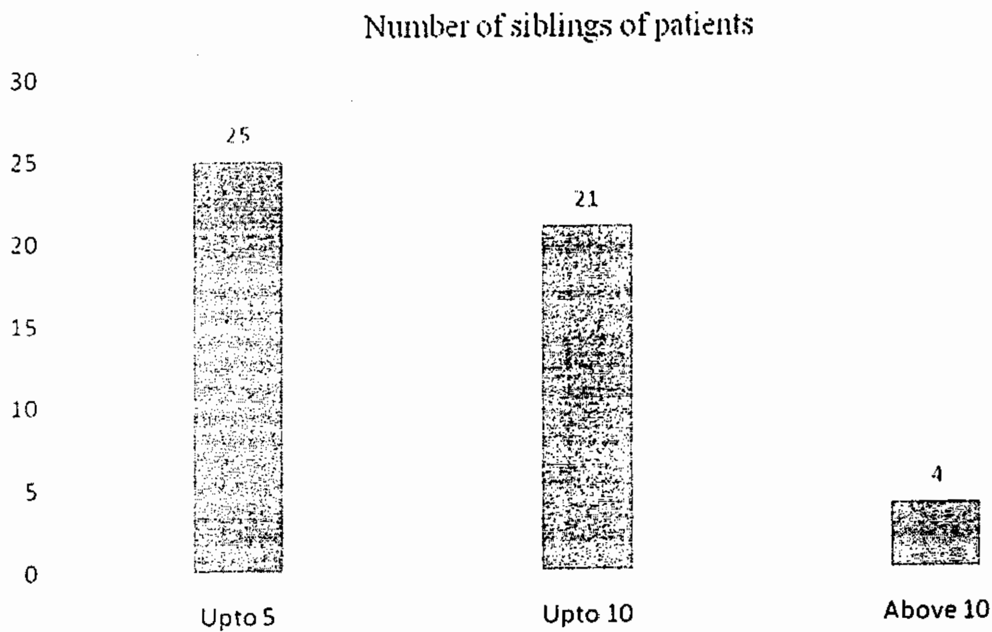

Figure 12. Graphical representation of number of siblings of patients in the study population

Table 3.

Diagnosis of psychiatric disorders in the study population (n = 50)

Psychiatric disorders	F	%
Depression	9	18
Anxiety	5	10
Schizophrenia	3	6
Dissociative	6	12
Behavioural problems	1	2
PTSD	1	2
Aggressive outburst	5	10
Epilepsy	4	8
Personality disorder	3	6
Conversion disorder	7	14
Learning disability	1	2
OCD	2	4
Somatic symptoms	2	4
Autism	1	2

Table 3 showed that majority (18%) of patients were depressed, 14% had conversion disorder, 12% had dissociative disorder, 10% had anxiety, 10% had aggressive outbursts, 8% had epilepsy, 6% had schizophrenia and personality disorder, 4% had OCD and Somatic symptoms, and 2% had behavioural problems, PTSD, learning disability & autism.

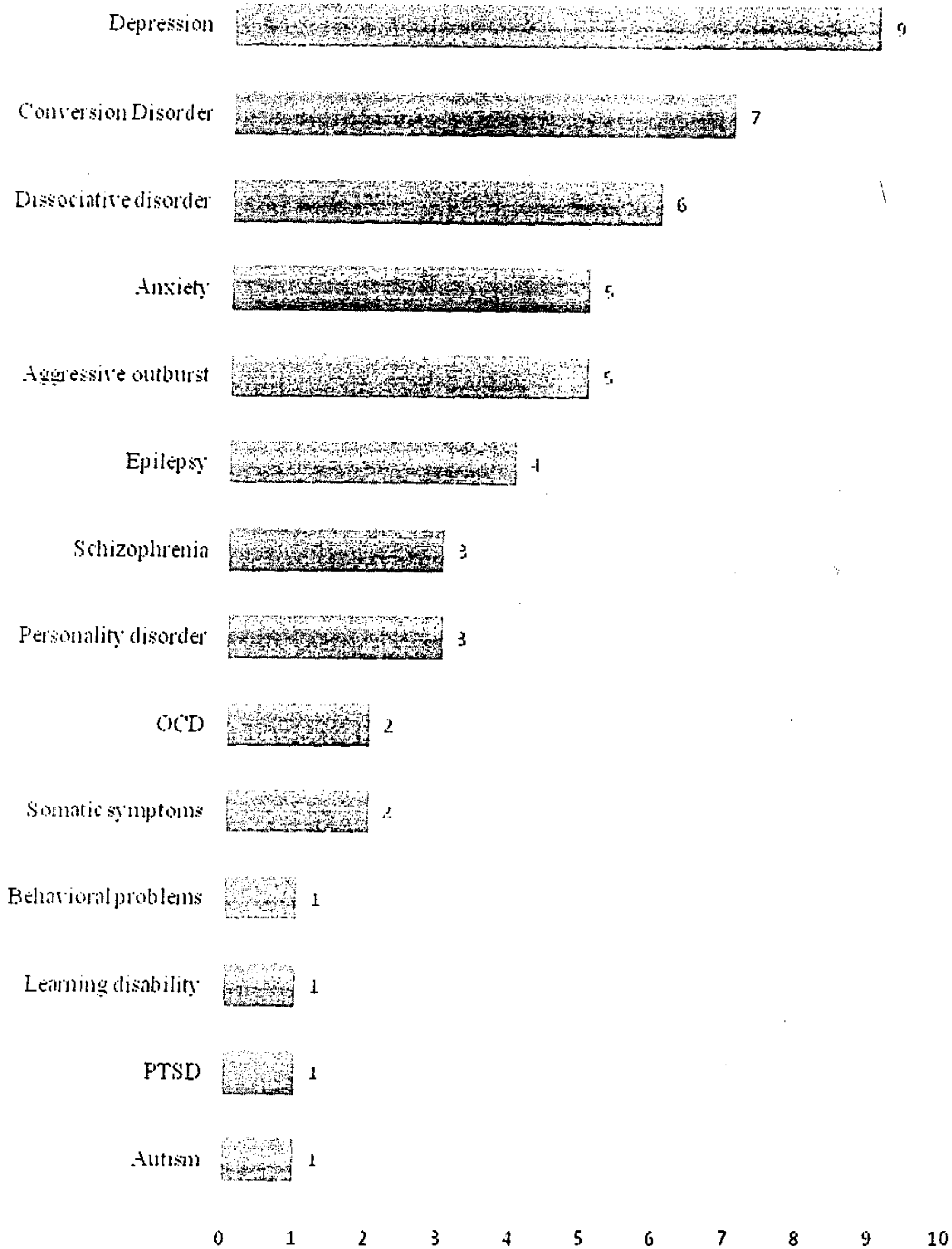

Figure 13. Graphical representation of diagnosis of psychiatric disorders in the study population

Table 4.

Problem severity in the study population (n = 50).

Variables	Category	N	%
Problem severity	Mild	10	20
	Moderate	19	38
	Severe	21	42

Table 4 showed that 42% of patients had severe, 38% had moderate, and 20% had mild level of mental illness.

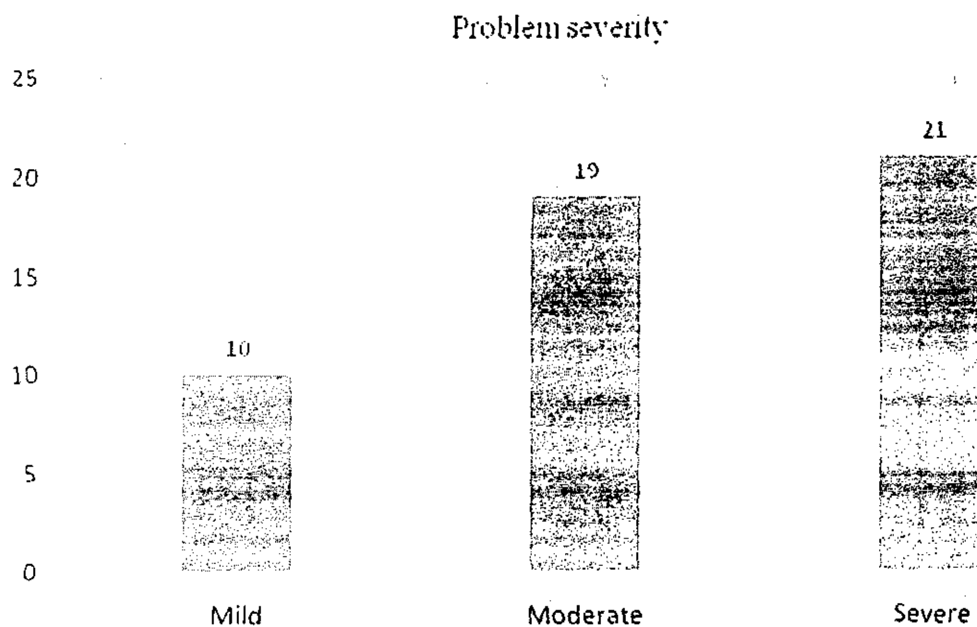

Figure 14. Graphical representation of problem severity in the study population.

Table 5

Bivariate Correlations between the Intensity of conventional beliefs before seeking proper mental health services, Social Stigma and Preference / attitudes towards Proper Mental Health before treatment

Variables	1	2	3
1. Intensity of conventional beliefs before seeking proper mental health services	--		
2. Social Stigma	**.047**	--	
3. Preference / attitudes towards Proper Mental Health before treatment	**-.664****	-.112	--

Note. Correlations marked with an asterisk (**) were significant at p < .01.

Table 5 shows that there was a significant negative relationship between intensity of conventional beliefs before seeking proper mental health services and preference/attitudes towards proper mental health before treatment $r = -.664, p < 0.001$, and there was no significant relationship between Intensity of conventional beliefs before seeking proper mental health services and social stigma $r = 0.047$, $p > 0.05$.

Table 6

Bivariate Correlations between the Intensity of conventional beliefs before seeking proper mental health services, Social Stigma and Preference/ Attitudes towards Traditional Healing Practices before starting treatment

Variables	1	2	3
1. Intensity of conventional beliefs before seeking proper mental health services	--		
2. Social Stigma	**.047**	--	
3. Preference/ Attitudes towards Traditional Healing Practices before starting treatment	**.765****	.212	--

Note: Correlations marked with an asterisk (**) were significant at $p < .01$.

Table 6 shows that there was a significant relationship between intensity of conventional beliefs before seeking proper mental health services and Preference/Attitudes towards Traditional Healing Practices before starting treatment $r = .765$, $p < 0.001$and there was no significant relationship between Intensity of conventional beliefs before seeking proper mental health services and social stigma $r = 0.047$, $p > 0.05$.

Table 7

Bivariate Correlations between the Duration of the problem and Intensity of conventional beliefs after seeking proper mental health services

Variables	1	2
1. Duration of the problem	--	
2. Intensity of conventional beliefs after seeking proper mental health services	.265*	--

Note: Correlations marked with an asterisk (*) were significant at p < .05

Table 7. Shows significant relationship between duration of the problem and intensity of conventional beliefs after seeking proper mental health services $r = .265$, $p < 0.05$.

Table 8

Bivariate Correlations between the Intensity of conventional beliefs before seeking proper mental health services and Preference / attitudes towards Proper Mental Health before treatment and Intensity of conventional beliefs after seeking proper mental health services and Preference / attitudes towards Proper Mental Health after treatment.

Variables	1	2	3	4
1. Intensity of conventional beliefs before seeking proper mental health services	--			
2. Preference / attitudes towards Proper Mental Health before treatment	-664**	--		
3. Intensity of conventional beliefs after seeking proper mental health services	.700**	-.528**	--	
4. Preference / attitudes towards Proper Mental Health after treatment	-.492**	.519**	-.830**	--

Note. Correlations marked with an asterisk (**) were significant at $p < .01$.

Table 8. Shows significant negative relationship between Intensity of conventional beliefs before seeking proper mental health services and Preference/attitudes towards Proper Mental Health before treatment $r = -.664$, $p < 0.001$. It also shows a significant negative relationship between Preference/attitudes towards Proper Mental Health before treatment and Intensity of conventional beliefs after seeking proper mental health services $r = -.528$, $p < 0.001$. The table further shows significant negative relationship between Intensity of conventional beliefs after seeking proper mental health services and Preference/attitudes towards Proper Mental Health after treatment $r = -.830$, $p < 0.001$.

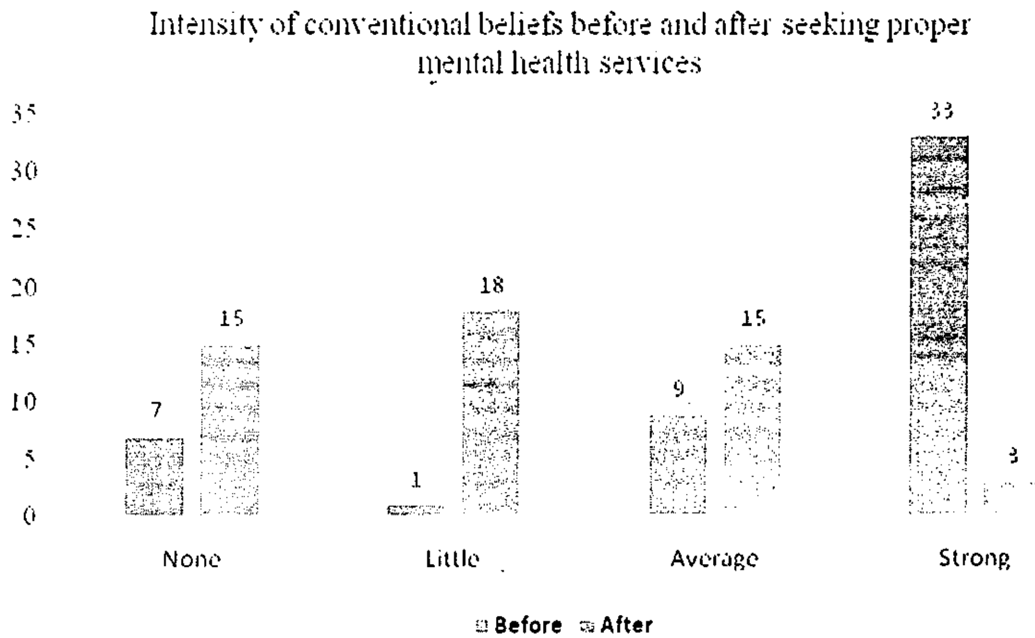

Figure 15. Graphical representation of Intensity of conventional beliefs before and after seeking proper mental health services

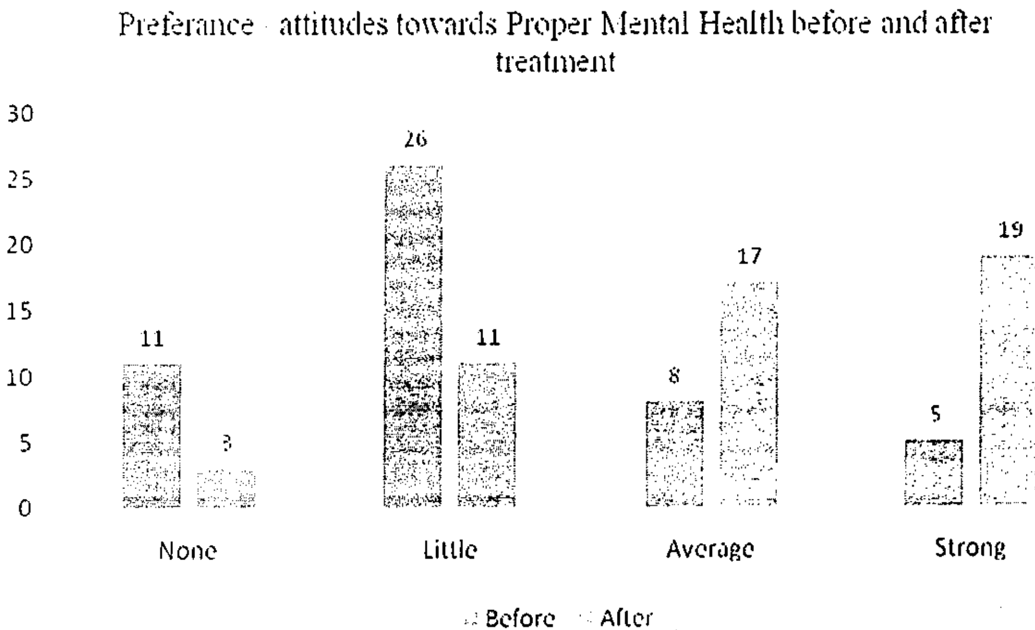

Figure 16. Graphical representation of Preference / attitudes towards Proper Mental Health before and after treatment

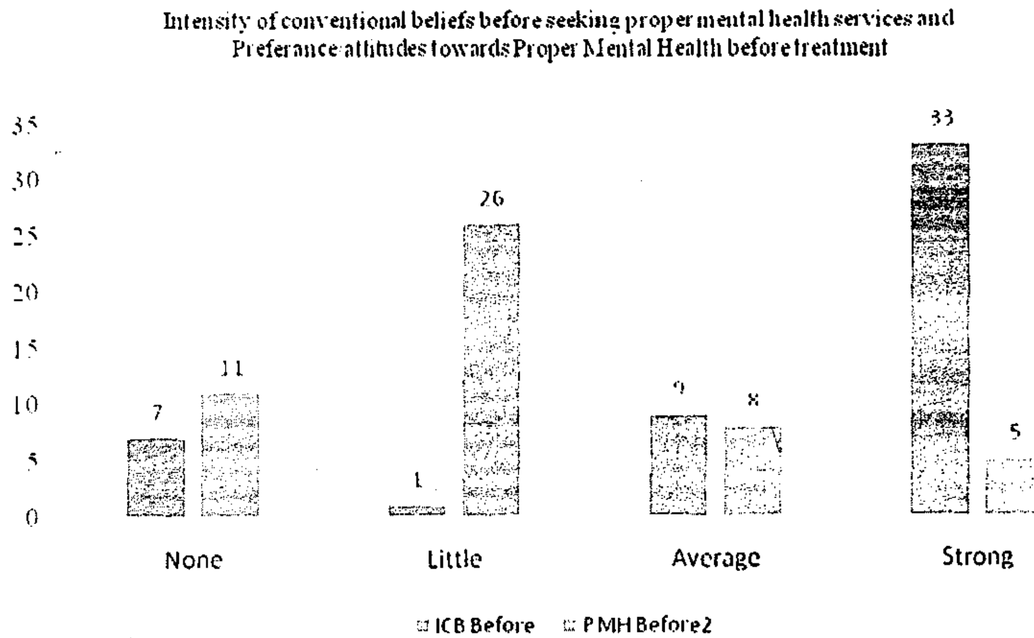

Figure 17. Graphical representation of Intensity of conventional beliefs before seeking proper mental health services and Preference / attitudes towards Proper Mental Health before treatment

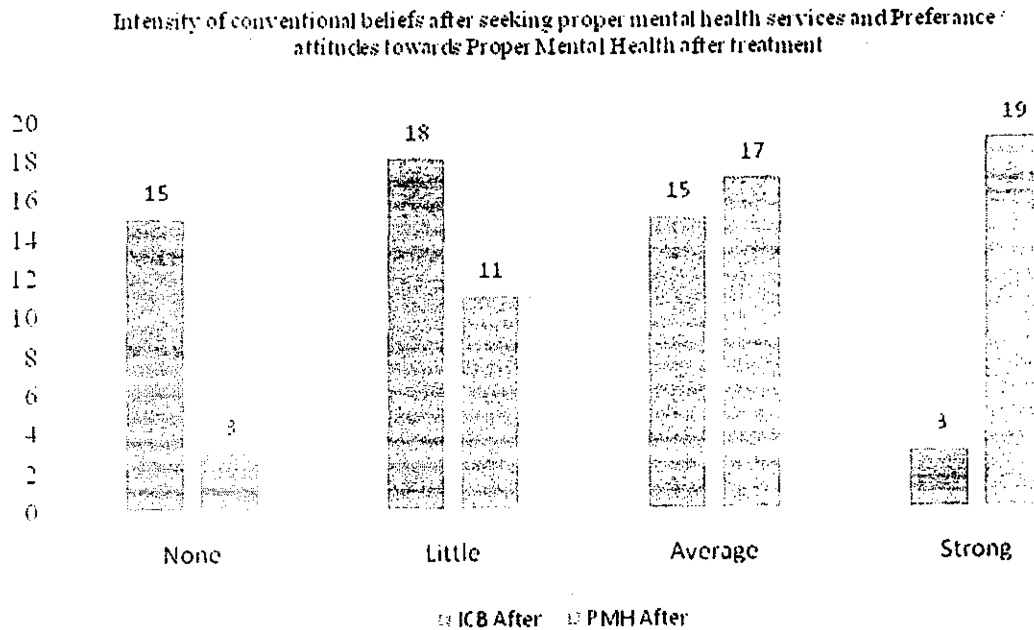

Figure 18. Graphical representation of Intensity of conventional beliefs after seeking proper mental health services and Preference/attitudes towards Proper Mental Health after treatment

Table 9

T-test analysis between male and female on variable of Intensity of conventional beliefs before seeking proper mental health services (ICBbfMh)

			Groups					
			Male (n = 32)		Female (n = 18)			
	N	*df*	*M*	*SD*	*M*	*SD*	*t*	*P*
ICBbfMh	50	48	3.50	.950	3.11	1.231	1.247	.05

Note. M= Mean. SD= Standard Deviation. *ICBbfMh*= Intensity of conventional beliefs before seeking proper mental health services.

Table 9 an independent sample t-test indicated that there was no significant difference between male (M = 3.50, p = .05) and female (M = 3.11, SD = 1.231), t (48) = 1.247, p = .256 on Intensity of conventional beliefs before seeking proper mental health services.

Table 10

T-test analysis between LSES and MSES on variable of Intensity of conventional beliefs before seeking proper mental health services (ICBbfMh) and Social Stigma

			Groups				
			LSES		MSES		
	N	df	M	SD	M	SD	t
ICBbfMh	50	48	3.81	.603	3.23	1.134	2.644*
Social Stigma	50	48	41.45	2.161	41.10	4.363	.257

Note. *$p < .05$, M= Mean. SD= Standard Deviation. *ICBbfMh*= Intensity of conventional beliefs before seeking proper mental health services. LSES= Lower socioeconomic status. MSES= Middle socioeconomic status.

Table 10 An independent sample t-test indicate that Intensity of conventional beliefs before seeking proper mental health services were significantly higher in people with LSES (M = 3.81, SD = .603) than in people in MSES (M = 3.23, SD = 1.134), t (48) = 2.644, p = .029. There was no significant difference between LSES (M = 41.45, SD = 2.161) and MSES (M = 41.10, SD = 4.363), t (48) = .257, p = .715 on social stigma score.

Table 11

Descriptive Statistics and t-test results for Intensity of conventional beliefs for seeking proper mental health services (ICB), Preference / attitudes towards Proper Mental Health treatment (PAMH). Preference/ Attitudes towards Traditional Healing Practices starting treatment (PATH).

	Before		After						
Outcome	M	SD	M	SD	N	95% CI	R	T	df
ICB	3.36	1.06	2.10	.91	50	1.03, 1.48	.700**	11.45**	49
PAMH	2.14	.88	3.04	.92	50	-1.15, -.65	.519**	-7.18**	49
PATH	3.26	.98	1.96	.92	50	1.05, 1.55	.571**	10.37**	49

Note. ** = $p < .01$, M= Mean. SD= Standard Deviation. CI= Confidence Interval.

Table 11 A paired sample t-test was computed to analyse the difference between Intensity of Conventional Beliefs (ICB), Preference/Attitude towards Proper Mental Health Treatment (PAMH), and Preference/Attitude towards Traditional Healing Practices (PATH) both before and after starting proper mental health treatment. A significant difference in all three variables were found. Results of the paired-samples t-test show that mean ICB differs before starting treatment (M = 3.36, SD = 1.06) and after starting treatment (M = 2.10, SD = .91), t(49) = 11.45, p <.001, 95% CI for mean difference 1.03 to 1.48, r = .700). Which indicated a clear decrease in the intensity of conventional beliefs. Mean PAMH differs before starting treatment (M = 2.14, SD = .88) and after starting treatment (M = 2.14, SD = .88), t(49) = -7.18, p <.001, 95% CI for mean difference -1.15 to -.65, r = .519) which shows a significant difference and the tendency towards proper mental health has profoundly increased. Analyzing third variable through t-test, the results indicated that mean PATH before starting mental health treatment (M = 3.26, SD = .98) is significantly different from mean PATH after starting treatment (M = 1.96, SD = .92), t(49) = 10.37, p <.001, 95% CI for mean difference -1.05 to 1.55, r = .571).

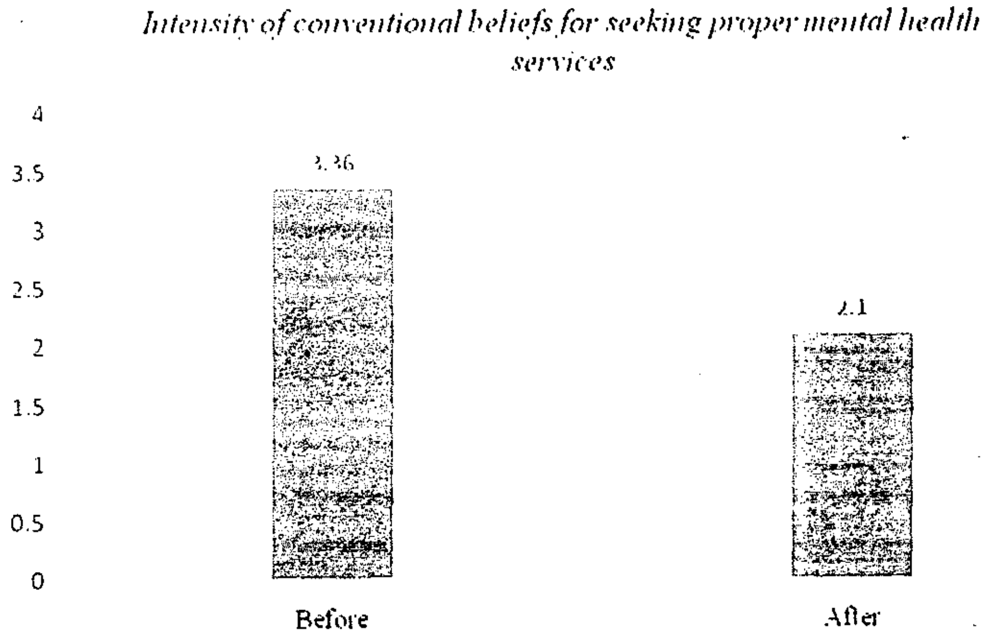

Figure 19. Graphical representation of Intensity of conventional beliefs before & after for seeking proper mental health services

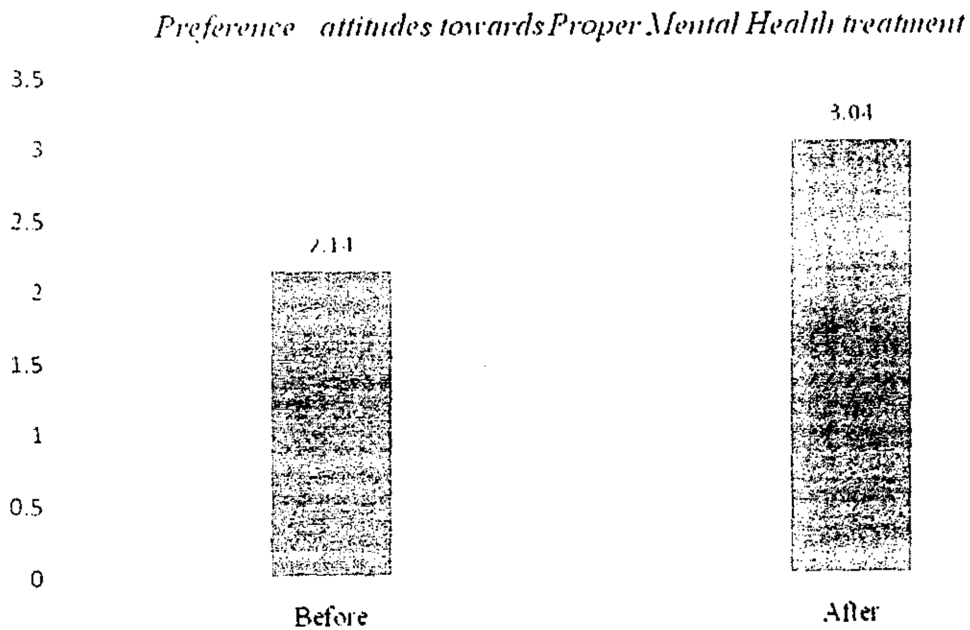

Figure 20. Graphical representation of Preference / attitudes before & after towards Proper Mental Health treatment.

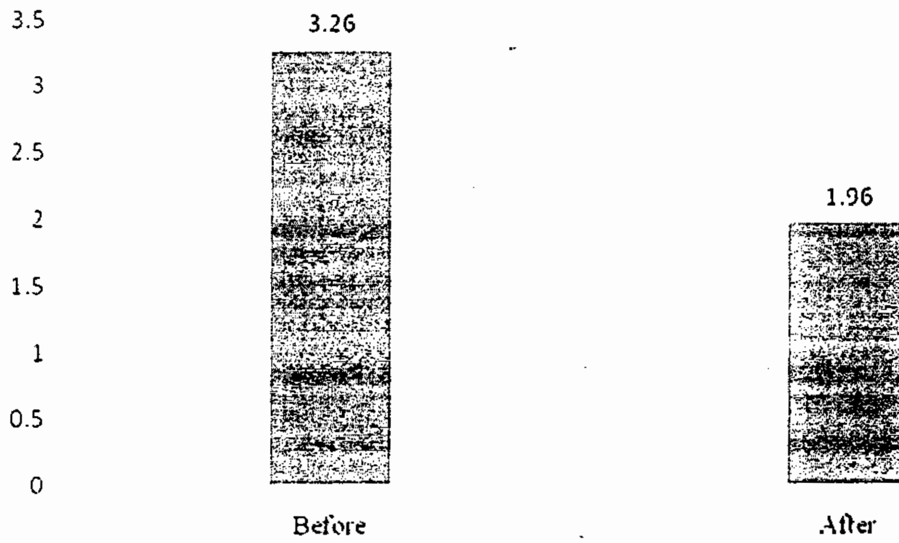

Figure 21. Graphical representation of Preference/ Attitudes before & after towards Traditional Healing Practices starting treatment

Discussion

This research study is carried out to know the impacts of social stigma and conventional beliefs on the choice of treatment for individuals with mental illness. It explores explanation of stigma (being labelled due to mental illness), as people associate a negative image to the person having mental illness or consulting mental health services/professionals i.e. Psychiatrist and Psychologist, which ultimately lead to a state when the person suffering from mental illness or his family deny the actual problem and hides it. Denying and hiding the problem along with misconception or misunderstanding of the problem results in delay in approaching proper mental health service/professional. This delay is extremely costly to both the sufferer and his family in terms of duration, expense, and pain of the problem.

The major problem with individuals having mental health issues is that they could not make decision for the treatment modality due to different reasons like beliefs held by family members of the individual with mental illness, regarding mental illness and the associated label with certain mental illness. Now it was solely dependent on the family members whether the patient would receive a treatment or not. If their answer was yes to treatment, then there was another problem of choosing method of treatment, and this was mostly dependent on the family members' perception about that mental illness.

As the study aim to find the impact of misconception and a fear of labelling on access to proper mental health service, so the results of this study have indicated the significant relationship between misconception about mental illness and its mistreatment. For example the study found that the individuals who had less awareness of the mental illness, and thought that the problem is due to black magic, evil eye, abundance of sins, and possession of jinn, initially took their patients, for treatment to traditional/faith healers. But later on as they were

guided by different people including relatives who had some know how, medical doctors or some other people with better understanding of the problem and its treatment, they took their patient to proper mental health care institutions and clinics, where they found some improvements in patients' conditions and were finally convinced that the problem was not as they had perceived but a real mental illness. Although the fear of labelling the family or person him/her-self with mental illness was not as significant as was hypothesized in this study but still the respondents expressed that the society consider or label a person with mental illness as mad locally called 'pagal' (response of interviewees) a stigmatized term because we don't have any other word than this stigmatized label.

The findings of this study indicated that majority of patients were depressed (18%) followed by conversion disorder (14%) dissociative disorder (12%), anxiety and aggressive outbursts (10%) each, epilepsy (8%), schizophrenia and personality disorder (6%). 42% patients had severe and 38% had moderate level of problem intensity.

In this study conventional beliefs refers to the lay or baseless interpretations of purely psychiatric disorders. The results of this research showed a strong negative association between conventional beliefs and seeking proper mental health service both before and after starting treatment at mental health care centres or clinics as were found in previous studies conducted (Zartaloudi & Madianos,. 2010; Aseel Hamid & Adrian Furnham,. 2013; Jean Mercer,. 2012) The individuals who had conventional beliefs with higher intensity, they were least likely to bring their patients to proper mental health care centres for proper treatment. On the other hand when after getting some guidance and observing the positive output of proper mental health service in terms of improving mental health of the patients the intensity of conventional beliefs declined and preference toward proper mental health treatment increased significantly. Furthermore the higher intensity of conventional beliefs

also played a significant role in family members' choice for the modality of treatment of their patients like people with strong conventional beliefs approached traditional/faith healers for the treatment of the individual with mental illness. Findings of this study is similar to the findings of other studies (Nguyen, A. 2003; Hussein, 1991; Khalifa & Hardie, 2005; Al-Habeeb. 2004; Johnsdotter, S et al. 2011; Abu-Ras & Abu-Bader. 2008; (Dols. 1987; Alaqeel A et al. 2013).

Surprisingly the results of current study are not in line with the findings of previous studies (Corrigan et al. 2004; Corrigan & Watson. 2002; Corrigan & Kleinlein. 2005; Corrigan, Watson, & Miller, 2006; Tsang et al. 2003a, 2003b; Cinnirellaet al. 1999; Gilbert et al. 2007; Haque 2004; Rethink. 2007; Weatherhead et al. 2010; Youssef & Deane 2006; Pilkington et al. 2011) that social stigma associated with mental illness didn't affect the decision of the family members of an individual with mental illness. These are the issues which make patient and his family reluctant of seeking proper mental health service. This could be the result of cultural variations.

It is explored in this study that even after starting proper psychiatric treatment or psychological rehabilitation process, if the sufferings were prolong in terms of duration and expense, the family which already had conventional beliefs, stick to their own unscientific understanding and explanation of that mental illness and considered it wastage of time and money treating their patient in proper mental health care institutions. A significant association was found between intensity of conventional beliefs after starting proper mental health treatment and duration of the problem.

As was assumed that holding conventional beliefs about psychiatric disorders people will be least willing to approach proper mental health services (Zartaloudi & Madianos,. 2010; Aseel Hamid & Adrian Furnham,. 2013; Jean Mercer,. 2012).

Findings of this study supported this assumption and the families who had strong conventional beliefs before and after starting proper treatment of their patient with mental illness were not preferring to approach or continue treatment of their patients in mental health care clinics and institutions.

The current study also explored that the families which were guided by relatives, medical doctors or they observed improvements in conditions of other such patients who were receiving proper mental health treatment they were convinced and the intensity of conventional beliefs they held before gradually decreased. Due to this decrease in level of conventional beliefs they preferred to treat their patient under the supervision of mental health professionals. Starting the treatment under mental health professionals lead to a further decline in conventional beliefs to significant low level. It can be said that intensity of conventional beliefs was inversely related to preference towards proper mental health treatment. If one had strong conventional beliefs, then he/she would have negative attitude towards proper mental health treatment and rehabilitation process, and if the conventional beliefs were weak, individual had positive attitude towards proper mental health treatment.

In previous studies socioeconomic status was also reported as a major factor involved in conformity to conventional beliefs and fear of being stigmatized (study adding). The people with lower socioeconomic status than the middle or higher socioeconomic status were more prone to have conventional beliefs and social stigma. Current study only found the link between socioeconomic status and conventional beliefs, the participants who belonged to low socioeconomic background had strong conventional beliefs than those who belonged to middle socioeconomic status, but there was no noticeable effect of difference in socioeconomic status on social stigma.

It was also explored in current study that there was a significant difference in the Intensity of convention beliefs before starting proper treatment and after starting proper

mental health treatment. Before starting proper mental health treatment the caregivers had profoundly strong conventional beliefs and misperceived the psychiatric disorder of their patients as the result of possession of jinn, black magic or evil eye etc. But after the guidance by relatives, medical doctors and the positive output of the treatment procedure made their views and beliefs shifted to a more logical and scientific way.

Furthermore, a significant difference and shift in preference towards proper mental health service was explored in this study, as people had a strong negative attitude towards proper mental health service before starting proper mental health treatment, but later on after guidance and improvement in condition of their patient let them convinced strongly towards seeking proper mental health service.

A profound change was also explored in preference for traditional healing practices. Before starting mental health treatment majority of study population had a strong positive attitude towards traditional healing practices and approached traditional/faith healers for treating their family member with psychiatric disorder. But after the poor outcome of traditional healing methods and useful guidance by others they changed and had least preference towards traditional treatment afterwards.

Conclusion

Generally and particularly in developing and least developed countries, mental illness is considered a stigma & misperceived as to be the result of gods' punishment, abundance of sins, deviation from the right path, black magic, possession by jinn or supernatural beings, and evil eye etc. Pakistan, a developing and multicultural country where religion & cultural values are considered deeply sacred, and people have a deep affiliation with religion and cultural beliefs and values. Where literacy rate is significantly low, majority of population live in rural areas under poverty line, people believe in the same explanation found in other least developed and developing nations. These misperceptions and fear of labelling have significant influence on the choice for treatment methods.

This study was carried out to find the impact of conventional beliefs (misperceptions) in addition social stigma on the choice of treatment modality for mental illnesses. The people who misperceive mental illnesses as the possession by jinn, or black magic and associate some label of shame and dishonour, they try to find a way out not for mental illness but for jinn possession and black magic, so they do not approach proper mental health service but instead go to traditional and faith healers to solve the problem, which is culturally less stigmatized as well. Level of awareness/knowledge about mental illness, gender difference, socioeconomic status and duration of mental illness were the supposed main factors in developing conventional beliefs & social stigma.

Results of current study supported the assumption and found significant influence of conventional beliefs on choosing treatment methods for individuals with mental illness. Majority of study population, whose conventional beliefs were changed from strong to weak intensity after guidance & seeking proper mental health treatment, had a more positive attitude towards proper mental health treatment, while a small proportion of participants who held strong conventional beliefs both before and after starting proper mental health treatment,

had a strong negative attitude towards proper mental health treatment. Their views remained unchanged due to the long suffering and no improvement in their patients' condition even after treatment. While social stigma unexpectedly showed no significant influence on the preference of treatment method. People holding strong conventional beliefs preferred traditional and religious treatment practices. Further-more, it was also found that people from low socioeconomic background held strong conventional beliefs than those of middle socioeconomic background, the result of this study is in accordance to previous studies. The study explored positive relationship between religious affiliation and intensity of conventional beliefs.

On the basis of the important results obtained from this study, it is suggested to initiate public awareness programs, both at government and private level. Government and Non Profit/Govt Organization should train the existing mental health professionals. Federal, Provincial and Local authorities, can play a key role in public awareness campaign through seminars, meetings with public and lectures. Our media can play an important role in spreading awareness about mental health. TV talk shows, Dramas, documentaries and other useful programs can be very worthwhile in this regards.

There should be legislation to discourage unprofessional, unscientific and traditional curative practices, which are amongst the key reasons for worsening the condition of patients with mental illnesses.

It is humbly suggested to religious scholars and mental health professionals to work in coordination for the betterment of humanity. Both should mutually find if there are any religious explanations for mental illnesses and their treatment in the revealed teachings. Which could be very useful for treating mental illnesses of almost all patients with mental illnesses.

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Appendix A

Consent Form

میں شعبہ نفسیات، بین الاقوامی اسلامی یونیورسٹی اسلام آباد کا طالب علم ہوں۔ میں نفسیاتی مسائل سے جڑے معاشرتی رسوائی کے اندیشوں کی وجہ سے نفسیاتی مسائل کے علاج میں رکاوٹوں پر تحقیق کر رہا ہوں جو کہ نفسیاتی مسائل کو سمجھنے اور اُن کو حل کرنے میں نہایت کار آمد ثابت ہوگی۔

اس تحقیق میں آپ کی شمولیت اورتعاون انتہائی اہمیت کا حامل ہے۔

اس تحقیق میں آپ کی شمولیت اور فراہم کردہ معلومات ہر طرح سے مخفی اور راز میں رکھی جائنگی۔

اس تحقیق میں آپ کی شمولیت مکمل طور پر آپ کی مرضی پر منحصر ہے جس میں کسی بھی طرح کا دباؤ کا عمل دخل نہیں ہوگا۔

اگر آپ اپنی مرضی سے اس تحقیق کا حصہ بننا چاہتے ہیں تو نیچے اپنے دستخط کر دیجیے۔ شکریہ

____

کوائف

(کیئر ٹیکر) نام:__________ عمر:__________ جنس:__________ تعلیم:__________

ازدواجی حیثیت:__________ میاں/ بیوی کی ملازمت :__________ متاثرہ شخص سے رشتہ:__________

مالی حالات:__________ ذرائع آمدن:__________ مذہب سے وابستگی:__________

رہائشی علاقہ (شہری) (دیہی)

(کلائنٹ) نام:__________ (ضروری نہیں) عمر:__________ جنس:__________ تعلیم:__________

مسئلہ:__________ مسئلے کی شدت:__________ عرصہ :__________ بہن بھائیوں کی تعداد:__________

والدین:__________ پہلے کبھی کسی ماہر نفسیات یا نفسیاتی ڈاکٹر کی خدمات حاصل کی ہے (ہاں) (نہیں)

Appendix C

Perceived Public Stigma Scale

بیانات	بالکل متفق	متفق	کسی حد تک متفق	کسی حد تک غیر متفق	غیر متفق	بالکل غیر متفق
1. بہت سے افراد ایسے شخص کو اپنی مرضی سے بطورقریبی دوست قبول کرلیں گے جس نے ذہنی عارضہ کا علاج کروایا ہو۔						
2. بہت سے افراد اس بات پر یقین رکھتے ہیں کہ جس شخص نے ذہنی عارضہ کا علاج کروایا ہو وہ اُتنا ہی ذہین ہوتا ہے جتنا کہ ایک اوسط شخص۔						
3. بہت سے افراد اس بات پر یقین رکھتے ہیں کہ جس شخص نے ذہنی عارضہ کا علاج کروایا ہو وہ اُتنا ہی قابلِ اعتبار ہوتا ہے جتنا کہ ایک اوسط شخص۔						
4. بہت سے افراد ایسے شخص، جس نے ذہنی بیماری سے مکمل طور پر شفاء حاصل کرلی ہو، کو سرکاری سکول میں چھوٹے بچوں کا اُستاد قبول کرلیں گے۔						
5. بہت سے افراد محسوس کرتے ہیں کہ ذہنی صحت کے لیے علاج کروانا ذاتی ناکامی کی علامت ہے۔						
6. بہت سے افراد ایسے شخص کو اپنے بچوں کی دیکھ بھال کے لیے نہیں رکھیں گے جس نے ذہنی عارضہ کا علاج کروایا ہو، گو کہ وہ کچھ عرصے سے ٹھیک ہو۔						
7. بہت سےافراد ایسے شخص کے بارے میں کم ہی سوچتے ہیں جس نے ذہنی عارضہ کا علاج کروایا ہو۔						
8. ملازمت دینے والے بہت سے افراد ایسے شخص کو جس نے ذہنی عارضہ کا علاج کروایا ہو کو کام پر رکھ لیں گے اگر وہ اسکا اہل ہو۔						
9. بہت سے افراد اُس شخص کی درخواست کو جس نے ذہنی عارضہ کا علاج کروایا ہو پر دوسرے درخواست گزار کو فوقیت دیں گے۔						
10. میرے حلقے میں بہت سے افراد ایسے شخص کے ساتھ جس نے ذہنی عارضہ کا علاج کروایا ہو، کے ساتھ ویسا ہی برتاؤ کرینگے جیسا کہ دوسروں کے ساتھ ۔						
11. بہت سے بالغ افراد ایسے شخص سے ملنے جلنے سے ہچکچائیں گے جو شدید ذہنی مرض کی وجہ سے ہسپتال داخل رہا ہو۔						
12. اگر یہ معلوم ہو جائے کہ کسی شخص نے ذہنی عارضے کا علاج کروایا ہے تو اکثر افراد اُس شخص کی رائے کو سنجیدگی سے نہیں لیں گے۔						

Interview Guide for Conventional Beliefs

کیا آپ کا عزیز اپنے روزمرہ کے معمولات زندگی کواُسی طرح انجام دے پاتا/پاتی ہے جس طرح اُس کے عمر کے دوسرے لوگ کرپاتے ہیں:-

1. آپ کے خیال میں آپ کے عزیز کو کیا مسئلہ/مسائل ہے/ہیں ؟
2. ان مسائل کی کیاممکنہ وجوہات ہوتی ہیں؟
3. آپ کے عزیز ہی ان مسائل سے کیوں گزررہے ہیں؟
4. آپ کے ارد گرد لوگ ان مسائل سے نمٹنے کے لیے کونسے طریقے استعمال کرتے ہیں؟
5. آپ کے خیال میں ان مسائل سے نمٹنے کے لیے کیا طریقہ کاراختیار کیا جاسکتاہے؟
6. آپ جادو ٹونہ، تعویذ اور جنات کے چمٹ جانےپر یقین رکھتے ہیں؟
7. علاج شروع کرنے سے پہلے سو میں سے کتنے فیصد آپ کو یہ لگتا تھا کہ آپ کے عزیز پر کسی نے جادوٹونہ یا تعویذ کیے ہیں، یا جنات کا اثر تھا؟
8. آپ نے اپنے عزیز کے ٹھیک ہونے کیلئے کیا طریقہ کار اپنایا ہوا ہے؟ یا اپنا رہے ہیں؟
9. آپ کو کسی پیر یا عالم کے پاس جاکر اپنے مریض کے علاج سے کس حد تک بہتری آئی، سو میں سے کتنے فیصد؟
10. کیا آپ کو اُس طریقے سے کوئی فائدہ ہوا؟ اگر فائدہ ہوا تو کس حد تک ہوا؟
11. اس طرح کے مسائل میں عملیات، دم اور تعویذ وغیرہ کس حد تک مفید ہے؟ اس طریقہ علاج کو سو میں سے کتنا فیصد اہمیت دیں گے؟
12. آپ اپنے عزیز کو اس مسئلے کےشروع ہونے سے کتنا عرصہ بعد یہاں علاج کے لیے لے کر آئے ہیں؟
13. کیا ایسی وجوہات تھیں جس کی وجہ سے آنے میں تاخیر ہوگئی؟
14. کیا آپ اس مسئلے کے حل کے لیے کسی ماہر نفسیات یا دماغ کے ڈاکٹر کے پاس جانا چاہیں گے؟ کیوں؟
15. آپ کو ذہنی صحت کے ادارے میں موجودہ طریقہ علاج پر سو میں سے کتنے فیصد بھروسہ ہے؟

Appendix E

INTERNATIONAL ISLAMIC UNIVERSITY, ISLAMABAD
FACULTY OF SOCIAL SCIENCES
Department Of Psychology
051-9019790

No.HOD/PSY-2015 Dated: 04-02-2015

Dr. Uzma Masroor

Clinical Psychologist

Dear Sir/ Madam

Greetings from Department of Psychology, International Islamic University, Islamabad. May I introduce **Mr. Inayat Shah**, he is an MS scholar in the department of Psychology, International Islamic University- Islamabad. He is working on his MS dissertation titled as **"ROLE OF SOCIAL STIGMA AND CONVENTIONAL BELIEFS IN SHAPING FAMILY PERCEPTION OF INDIVIDUALS WITH PSYCHIATRIC DISORDERS"** under my supervision. In this regard, yours cooperation is highly needed. If you kindly allow him to collect data from your prestigious Clinic, it would be a great assistance to our student to accomplish his research study. He will also acknowledge your kind cooperation in his dissertation and, upon your request, would share the findings of his research study.

Looking forward for the growing cooperation.

Regards

Dr. Muhammad Tahir Khalily

INTERNATIONAL ISLAMIC UNIVERSITY, ISLAMABAD
FACULTY OF SOCIAL SCIENCES
Department Of Psychology

051-9019790

No. HOD/PSY-2015 Dated: 04-02-2015

The Head
Institute of Psychiatry,
Benazir Bhutto Hospital,
Rawalpindi.

Dear Sir

Greetings from Department of Psychology, International Islamic University, Islamabad. May I introduce **Mr. Inayat Shah**, he is an MS scholar in the department of Psychology, International Islamic University- Islamabad. He is working on his MS dissertation titled as **"ROLE OF SOCIAL STIGMA AND CONVENTIONAL BELIEFS IN SHAPING FAMILY PERCEPTION OF INDIVIDUALS WITH PSYCHIATRIC DISORDERS"** under my supervision. In this regard, yours cooperation is highly needed. If you kindly allow him to collect data from your prestigious Institution, it would be a great assistance to our student to accomplish his research study. He will also acknowledge your kind cooperation in his dissertation and, upon your request, would share the findings of his research study.

Looking forward for the growing cooperation.

Regards

Dr. Muhammad Tahir Khalily